

## DOCTORAL THESIS

### **Intellectual Disabilities - Differential Treatment Within Multi Agency Public Protection Arrangements**

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*Award date:*  
2015

*Awarding institution:*  
University of Roehampton

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**Intellectual Disabilities – Differential Treatment  
Within Multi Agency Public Protection Arrangements**

**by**

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**A thesis submitted in partial fulfilment of the requirements for  
the degree of PsychD in Forensic Psychology**

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**2014**

## **Abstract**

This research examined the prevalence, differential treatment and demographic and potential risk factors between two groups of offenders with Intellectual Disabilities (ID) and Intellectual Vulnerabilities (IV) and a non-ID/IV group managed by Multi-Agency Public Protection Arrangements in the South East of England. The sample included 250 offenders, aged between 15 and 70 years, 9 women and 241 men who were managed by level 2 and 3 MAPPA. Two studies were conducted.

Study One - The prevalence of the IV group was 25.6%. There were no significant differences between the number of external controls placed on the IV and non-IV groups. There was a significantly greater amount of external controls (police lead orders) placed on the ID group than the non-ID group. The IV group was over 5 times more likely to have language deficits than the non-IV group and twice as likely to have been in care as a child. When controlled for language deficits the IV group were twice as likely to have social skills deficits.

Study Two – The MAPPA minutes and files relating to the IV group identified in Study One were examined in more detail. The central issues relating to the IV group were analysed using Thematic Analysis. The main themes and sub themes identified were ‘Intellectual Vulnerability’ and sub themes ‘Mental Health’ and ‘Diversity Considerations,’ ‘Early Life Experiences’ which had sub themes of ‘Abusive Experiences’ and ‘Schooling/Education’ and finally ‘Offending Behaviour’ with the sub themes ‘Substance Misuse’ and ‘Victims Known or Vulnerable.’

The research identifies the issues of diagnosing intellectual disabilities/vulnerabilities accurately and the impact this has on reliable prevalence rates and comparisons. Some recommendations for good practice in working with such offenders within MAPPA are made.

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## **Acknowledgements**

I would firstly like to thank Professor Graham Towl, for bringing this qualification to my attention and for kindly sponsoring my first three years of study via the Ministry of Justice Office of the Chief Psychologist.

I would also like to express my thanks to Professor Robert Edelman, Professor David Crighton, and Dr Diane Bray who have been such a supportive and encouraging supervisory team.

I am grateful to Kent Probation Trust, my employers, who have allowed me time to undertake my study (particularly in the data collection phase when I was not in the office very much). Sadly Kent Probation ceased to exist on 31<sup>st</sup> May 2014 but I hope that this research will continue to inform the work of probation in the new National Probation Service.

I would also like to acknowledge all of the staff from the probation areas and police stations who generously gave up their time to facilitate my data collection.

Finally I could not have undertaken this work without the support and kindness of family and friends. But special thanks must go to my husband, Edward Szumowski who has supported me in so many ways throughout. I could not have got through this process without him.

## Chapter 1 – Introduction

There are a high percentage of offenders managed by the Criminal Justice System who have intellectual disabilities or difficulties. Prevalence rates vary from 7% (Mottram, 2007) to greater than 70% (Brier, 1989) depending on the criteria and assessment methodology employed. Brier (1989) also hypothesised that offenders with learning disabilities (LD) were more susceptible to engaging in anti-social behaviour, failing at school and being treated differently to offenders without learning disabilities. He suggested a number of possible reasons for a 'differential treatment' hypothesis. This theory will be tested by the current research as such 'differential treatment' could disadvantage offenders with learning disability. Indeed recent reports such as the Prison Reform Trust's 'No One Knows' (Talbot, 2007) and more recently Lord Bradley's (2009) review of people with mental health problems or learning disabilities in the criminal justice system (CJS) note the paucity of appropriately targeted resources for offenders with intellectual disabilities.

A further issue relates to the lack of consensus of assessment criteria for offenders with intellectual disabilities/difficulties. This is illustrated by the wide variance in prevalence rates as noted above. Due to this, a number of relevant issues pertaining to offender groups with intellectual difficulties are not being properly identified. Talbot (2007) and Bradley (2009) refer to the lack of proper screening or identification of offenders with LD. It is thus perhaps unsurprising that the range of presentational issues such as impulsivity, language difficulties, poor empathy, difficulty understanding and following instructions leads this group of offenders into difficulties within the CJS. They may also be exposed to a more punitive response from staff and suffer from a lack of

appropriate resources. Longitudinal studies, such as the Cambridge Study in Delinquent Development by Farrington (1995), have established a clear link between delinquency and low IQ. Therefore this continues to be an area that it is important for the forensic psychology field to research.

This chapter will firstly address the variety of diagnostic and inclusion criteria that have been offered for learning disability. It is helpful at this point to briefly consider terminology. Lindsay and Taylor (2010) discuss the use of the term intellectual disability (ID). They refer to the fact that the term intellectual disability and learning disability are used in a synonymous way in the UK, but that intellectual disability has gained international recognition as a preferred term. Indeed the researchers make reference to the American Association of Mental Retardation updating its title to the American Association for Intellectual and Developmental Disabilities. This is of importance to the research in order to provide an inclusive definition for intellectually disabled offenders for comparison with non-intellectually disabled offenders. The link between intellectual functioning/disability and offending will be considered. The prevalence rates of intellectual disability within the CJS will also be examined. Throughout the chapter the paucity of appropriate services for ID offenders will be highlighted.

Finally the context in which the research will take place will be outlined. Multi-Agency Public Protection Arrangements (MAPPA) is the risk assessment and management framework used by the Prison, Probation and Police services in the UK to manage high and very high risk offenders. The Home Office MAPPA Guidance (2009) advocates the use of specialist risk assessments for offenders with mental health issues or intellectual disabilities. However it does not offer further

guidance on what these assessments should be or how they may inform management of these offenders. A further aim of the research is to increase understanding of the offenders managed by the MAPPA who have intellectual disabilities as defined by the research criteria.

## **Definitions and Diagnoses of Intellectual Disability**

Whilst many such as Brier (1989), Lindsay & Taylor (2010) criticise the variation in criteria used, it is difficult to establish an exact definition based on exact assessment techniques. Intellectually disabled offenders are not a homogenous group. Talbot (2007) states ‘They are all individuals with a wide range of different life experiences, strengths, weaknesses and support needs. However many will share common characteristics, which might make them especially vulnerable as they enter and travel through the criminal justice system (p. 3).’

It is difficult to identify cause and effect of the multiple factors that link ID and offending. The stance of this research is to instead focus on the outcomes for offenders with ID. It is also based on the assumption that it is better to be over inclusive than under inclusive to try and ensure that offenders suffer least disadvantage in a system that has been designed very poorly to meet their needs.

## **Intellectual Disability Definitions**

Intellectual disability is just one term that can be used to describe a range of difficulties. Other terminology that has been used includes learning disability, learning difficulty, mental retardation or special needs. The differential terminology represents subtle differences in the inclusion or exclusion criteria for diagnoses.

Intellectual Disability is defined in different ways dependant on the definition being applied. One such definition is provided by the Diagnostic and Statistical Manual 4<sup>th</sup> Edition (DSM IV), (American Psychiatric Association, 1994). DSM IV uses the term mental retardation instead of intellectual disability which it defines by three co-existing criteria – age of onset within the developmental period before adulthood, significant impairment of intellectual functioning and significant associated impairment of adaptive functioning.

The International Classification of Diseases and Related Health Problems 10<sup>th</sup> Revision (ICD-10) World Health Organisation (1992) classification prompts assessment of intelligence via an intelligence quotient (IQ) assessment and consideration of the extent of impairment of behaviour. The IQ score taken into account is two standard deviations below the population mean, hence generally defined as below 70, i.e. diagnostic criteria of 69 or below. The ICD-10 defines learning disability as a ‘reduced level of intellectual functioning resulting in diminished ability to adapt to the daily demands of the normal social environment.’

In 2013 the American Psychiatric Association updated the Diagnostic and Statistical Manual of Mental Disorders to a fifth edition – DSM – 5 (2013). This provides one of the more useful revisions to the DSM IV (1994) terminology of ‘Mental Retardation’ and has replaced it with Intellectual Disability. DSM – 5 (2013) has been criticised as being too over inclusive in terms of some other disorders and ‘catch-all’ diagnoses by the British Psychological Society (2012). The DSM 5 criteria (in italics) for Intellectual Disability (Intellectual Developmental Disorder) are given in Table 1.1;

**Table 1.1 DSM 5 Criteria for Intellectual Disability**

A.	<i>Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.</i>
B.	<i>Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work and community.</i>
C.	<i>Onset of intellectual and adaptive deficits during the developmental period.</i>

The DSM 5 criterion also outlines severity levels which are described as ‘Mild, Moderate, Severe and Profound.’ It is interesting to note that DSM 5 defines the severity levels on the ‘basis of adaptive functioning, and not IQ scores.’ The authors question the validity of IQ scores in the lower

ranges. In the section entitled Significant Impairment of Intellectual Functioning below the issue of IQ measures is addressed.

The proposed criteria for a diagnosis of learning disability for DSM V (website accessed 19<sup>th</sup> August 2010) outlined an additional category of learning disabilities which gave the following definition; ‘*A group of disorders characterized by difficulties in learning basic academic skills (currently or by history), that are not consistent with the person's chronological age, educational opportunities, or intellectual abilities.*’ This was further refined in DSM 5 (2013) to the diagnostic category of Specific Learning Disorder, the criterion for which is outlined in italics in Table 1.2.

**Table 1.2 DSM 5 Criteria for Specific Learning Disorder**

A.	<i>Difficulties learning and using academic skills, as indicated by the presence of at least one of the following symptoms that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:</i>
1.	<i>Inaccurate or slow and effortful word reading (e.g. reads single words aloud incorrectly or slowly and hesitantly, frequently guesses words, has difficulty sounding out words).</i>
2.	<i>Difficulty understanding the meaning of what is read (e.g. may read text accurately but not understand the sequence, relationships, inferences, or deeper meanings of what is read).</i>
3.	<i>Difficulties with spelling (e.g. may add, omit, or substitute vowels or consonants).</i>
4.	<i>Difficulties with written expression (e.g. makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organization; written expression of</i>

	<i>ideas lacks clarity),</i>
5.	<i>Difficulties mastering number sense, number facts, or calculation (e.g. has poor understanding of numbers , their magnitude, and relationships; counts on fingers to add single-digit numbers instead of recalling the math fact as peers do; gets lost in the midst of arithmetic computation and may switch procedures).</i>
6.	<i>Difficulties with mathematical reasoning (e.g. has severe difficulty applying mathematical concepts, facts or procedures to solve quantitative problems).</i>
B.	<i>The affected academic skills are substantially and quantifiably below those expected for the individual's chronological age, and cause significant interference with academic or occupational performance, or with activities of daily living, as confirmed by individually administered standardized achievement measures and comprehensive clinical assessment. For individuals age 17 years and older, a documented history of impairing learning difficulties may be substituted for the standardized assessment.</i>
C.	<i>The learning difficulties begin during school-age years but may not become fully manifest until the demands for those affected academic skills exceed the individual's limited capacities (e.g. as in timed tests, reading or writing lengthy complex reports for a tight deadline, excessively heavy academic loads).</i>
D.	<i>The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory acuity, other mental or neurological disorders, psychosocial adversity, lack of proficiency in the language of academic instruction, or inadequate educational instruction.</i>
	<i>Note: The four diagnostic criteria are to be met based on a clinical synthesis of the individual's history (developmental, medical, family, educational), school reports, and</i>



	<i>psycho-educational assessment.</i>
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The range of diagnostic criteria and difficulties in obtaining detailed and appropriate assessments means that individuals may often be disadvantaged. They may be unable to access the support and services they need. Generally UK learning disability services will adhere to strict eligibility criteria of IQ below 70, childhood onset and significant impairment of intellectual functions in order to offer services to individuals. The impact of this may be that those who are ‘borderline’ cases and could greatly benefit from services do not receive them. There are also issues with relying purely on IQ scores which are outlined in the next section – significant impairment of intellectual functioning.

More recent reports on offenders with intellectual disability have taken a broader view in order to try and capture data on all of those who may be disadvantaged in the Criminal Justice System. The Prison Reform Trust report No One Knows, Talbot (2007) gave the following inclusion criteria for the study;

‘The term learning disabilities or difficulties thus include people who:

- Experience difficulties in communicating and expressing themselves and understanding ordinary social cues
- Have unseen or hidden disabilities such as dyslexia
- Experience difficulties with learning and/or have had disrupted learning experiences that have lead them to function at a significantly lower level than the majority of their peers
- Are on the autistic spectrum, including people with Asperger syndrome’

Similarly Lord Bradley's (2009) report utilised a definition comprised of that used by the No One Knows, Talbot (2007) report and the Governments 'Valuing People' White Paper (2001) which defined learning disability as;

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- A reduced ability to cope independently (impaired social functioning);
- Which started before adulthood, with a lasting effect on development.

Lord Bradley also included learning difficulties under the term learning disability. He used the Education Act 1996 definition as follows:

A child has a learning difficulty if:

- He has a significantly greater difficulty in learning than the majority of children of his age,
- He has a disability which either prevents or hinders him from making use of educational facilities of a kind generally provided for children of his age in schools within the area of the local education authority...

Hence the term learning disabilities is difficult to define exactly. As discussed later in the chapter the difficulty with consistent definition makes it difficult to compare studies and gain accurate prevalence rates.

## **Significant Impairment of Intellectual Functioning**

In order to establish whether an offender has a significant impairment of intellectual functioning there must first be an assessment to establish this. As noted above in DSM V this must be 'confirmed by both clinical assessment and individualized, standardized intelligence testing.' Possibly the most common assessment of intellectual functioning is the Weschler Adult Intelligence Scale 3<sup>rd</sup> Edition (WAIS III)<sup>1</sup>, Weschler (1999). The WAIS III has 14 subtests and gives information on the recipient's ability in a number of areas. Some subtests contribute to the verbal Intelligence Quotient (IQ) and measure crystallized intelligence which includes school acquired knowledge and comprehension. Other subtests contribute to the performance IQ and measure fluid intelligence which includes the ability to solve novel problems. This type of intelligence has a component of reasoning and does not depend as much on formal schooling.

However this leads to the difficulty of considering cause and effect in respect of school acquired knowledge. Does disrupted schooling lead to poor educational attainment or is poor ability at school a factor in leading to disruptive behaviour and exclusion? Regardless of the causality the outcomes for those excluded from school is especially poor. This is pertinent as many offenders have had disrupted schooling. Similarly school attachment (or lack of) is one of the strongest and most consistent predictors of the development of delinquency (Sampson & Laub, 2008). This may be linked to offender's not receiving appropriate learning support and subsequently ceasing to attend. It may also be attributed to poor parental support or role-modelling. Berridge, Brodie, Pitts, Porteous and Tarling (2001) examined the effects of permanent exclusion from school on the offending

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<sup>1</sup> During the course of the study the WAIS IV (2010) was published and came into wider use.

careers of young people. They found that, of the group who had been permanently excluded more than once, a disproportionate number had been assessed as having special educational needs. Of the 263 young people for whom complete Police records were held 117 had a record of offending following permanent exclusion, 47 had recorded offences before and after permanent exclusion and 14 had recorded offences before permanent exclusion. Berridge et al (2001) also found that the young people in the study suffered from a range of social and educational disadvantage. These young people had been, more frequently than non-excluded children, subject to issues such as sexual abuse, parental violence, frequent home moves and homelessness, bereavement and contact with the care system. Similarly OFSTED (1996) in a study of exclusions from secondary schools, refer to the backgrounds of excluded students as a 'grim catalogue of misery.' These backgrounds were found to include parental illness and bereavement, poverty which was often related to unemployment, racism, sexual or physical abuse and strained family relationships.

The outcome of a lack of engagement at school may be learning difficulties/disabilities or vice versa. Therefore it may be reasonably anticipated that there would be greater deficits in verbal IQ amongst the offender population, given that the verbal IQ measures crystallized intelligence which includes school acquired knowledge and comprehension and there is such a strong relationship between school failure and delinquency. Indeed Williams, Talbot, Bailey, Kroll, Chitsabesan and Kenning (2007) in their study of 301 young offenders found that verbal IQ scores were significantly lower than performance IQ scores, particularly in male offenders.

There are also issues with the way in which IQ tests are scored and reported upon. The WAIS III for example has a number of index scores in addition to the full scale, verbal and performance IQ

scores. The test yields a Verbal Comprehension, Perceptual Organisation, Working Memory and Processing Speed Index. Therefore the full scale IQ alone does not provide a complete picture and may hide specific deficits. Where there are large discrepancies between the subtest scores it may mean that the composite scores such as full scale or performance IQ are not readily interpretable and should not be reported. Where they are interpretable as indicative of individual's abilities and should be reported upon, the commonly used confidence intervals should be noted. As such an individual's full scale IQ may be 69 with a 95% confidence interval that it is between 67 and 72. Therefore they may or may not meet one of the diagnostic criteria for learning disabilities.

There are currently no formal screening tools available across the whole CJS. Whilst prison and probation based psychologists may well conduct WAIS III, or more recently WAIS IV assessments or the WASI (Wechsler Abbreviated Scale of Intelligence, a screening version of the WAIS using only 4 subtests) assessments to place offenders in mainstream or adapted Offending Behaviour Programme's (OBP's) the developmental and adaptive functioning aspects may not be properly assessed or taken into account.

A screening tool is currently being piloted in some prisons and probation areas called the LDSQ (Learning Disabilities Screening Questionnaire) (McKenzie & Paxton, 2006). The LDSQ appears to take a broader account of the range of difficulties. It prompts consideration of the level of ability in terms of telling the time from a clock face, reading, writing in addition to the social and adaptive issues of independent living and employment in the community. The LDSQ also considers the historical components of experience of statements of special education needs at school or any contact with a learning disabilities team. The LDSQ then calculates a probability index to prompt

further and more in depth assessment if required. McKenzie, Michie, Murray and Hales (2012) have published validity research on the LDSQ in forensic settings and found that the tool is able to identify ID quite effectively. The research identified a significant difference between the LDSQ scores of those who did and did not have an ID diagnosis.

In addition to considering whether significant impairment of intellectual functioning is present it is also important to consider how the impairment occurred. The diagnostic criteria only consider that the impairment has onset before adulthood, during the developmental period. Therefore it is important to consider the range of possible causes. For example cognitive impairment may be the result of later acquisition via accident or illness such as traumatic brain injury, substance misuse, tumours or strokes. This type of cognitive impairment can affect an individual's memory and also their ability to concentrate reason or manage their emotions effectively. In relation to head injury this can be relatively common among offenders who have taken more risks such as involvement in road accidents or been involved in more fights, (Huxx, Bong, Skinner, Belau and Sanger, 1998) or misused substances (Perron and Howard, 2008).

## **Traumatic Brain Injury**

Schofield, Butler, Hollis, Smith, Lee and Kelso (2006) reported that 82% of those recently received into custody in Australia had a traumatic brain injury (TBI) in the past. Williams, Cordan, Mewse, Tonks and Burgess (2010) studied the self-reported rate of TBI among a sample from a Young Offender Institute, Youth Offending Team and special needs school in the UK. The research

identified that 46% of the sample reported TBI with a loss of consciousness. Farrer, Frost and Hedges (2013) also found that juvenile offenders were three times more likely to have a TBI than controls. Williams et al's (2010) findings also established that a higher frequency of self-reported TBI was associated with more convictions and 3 or more TBIs associated with greater violence. Again the cause and effect needs to be considered i.e. does having a TBI make people more likely to behave violently or criminally or does being violent and criminal make you more likely to sustain TBIs? Therefore asking offenders whether they have sustained a serious head injury or been rendered unconscious for any reason is important in respect of understanding their presentation and informing decisions on future management.

The types of issues that can present as a result of brain injury are wide ranging. Some of the most common problems arising from brain injury are impaired working memory, impaired executive functioning and/or changes in behavioural and personality patterns. However it is interesting to note that the traits present in dysexecutive syndrome as defined by DSM IV are the same as the traits for antisocial personality disorder. These include impulsivity, lack of empathy, failure to inhibit, a lack of self perception, affective instability, aggression, disproportionate rage and suspiciousness (American Psychiatric Association, 2000). Similarly TBI can often be associated with impulsivity and a lack of affective empathy. Such traits have often featured in the description of persistent offenders (Jolliffe & Farrington, 2003). Therefore it would be necessary to know the cause of the traits in order to work with the person effectively. Rogers (2003) stated that given that many of the constructs of 'ASPD' are also constructs of 'dysexecutive syndrome' caution must be used to avoid any potential misattribution of behaviour as 'pure' personality disorder which may actually be the function of impaired cognitive processing due to an organic difficulty. This would also be important

in considering what sentence planning objectives to set that are actually achievable by the offender. Williams et al (2010) note 'it is likely that neuropsychological sequelae (problems with attention, memory and executive functions) would limit sufferers' capacity to fully engage in forensic rehabilitation to enable behaviour change.'

There is also a link between substance misuse and brain injury. This link can be causal i.e. the substance misuse intoxication effects contributed to the accident that caused the injury or that the substance misuse was responsible for the brain injury such as Korsakoff's syndrome. Corrigan (1996) found that a large proportion of adolescents and adults hospitalised for brain injuries had pre-injury substance use disorders. The prevalence of substance misuse amongst offenders is well documented. Fazel, Bains and Doll (2006) conducted a systematic review on substance misuse and dependence in prisoners. The thirteen studies reviewed yielded a sample of 7563 prisoners. They established that the estimates of prevalence for alcohol abuse and dependence in male prisoners ranged from 18 to 30% and 10 to 24% in female prisoners. Drug abuse and dependence prevalence estimates ranged from 10 to 48% in male prisoners and 30 to 60% in female prisoners. Other substances commonly used by young offenders such as solvents (or volatile substances) have also been found to be quite harmful to the brain (Takagi, Lubman and Yücel, 2011).

Other causes of a significant impairment of intellectual ability may be related to birth defects or chromosomal abnormalities such as Down's syndrome. They may also be due to pregnancy issues such as foetal alcohol syndrome. These may result in different presentational issues and difficulties in engaging and managing the individuals concerned.



Given the wide range of assessments and indicators of a significant impairment of intellectual functioning, the current research has sought to take account of this in operationalising the term intellectual disabilities to be as inclusive as possible. This is described in the thesis criteria for intellectual disabilities section below.

### **Significant Associated Impairment of Adaptive Functioning**

One of the other diagnostic criteria for learning disabilities is a significant impairment of adaptive functioning. What is meant by adaptive functioning is the ability of an individual to cope with the everyday demands of their environment. These could be considered in relation to independent living, community integration and the ability to use services such as banking, leisure and health services. Independent living would be the degree to which an individual could manage their self-care, domestic tasks and live independently. Community integration could include the ability to budget and shop as well as the use of public transport (Lindsay & Taylor, 2010). There are a range of assessments that can be used to assess adaptive functioning. The Vineland Adaptive Behavior Scales II (Sparrow, Cicchetti & Balla, 2005) are the second revision of the widely employed Vineland Social Maturity Scale (VSMS) (Doll, 1935), which was the first standardised adaptive behaviour test. The Vineland II has normative data which allows the assessor to consider the individual's adaptive behaviour in relation to that of the general population.

In considering this criterion in the context of offenders there may be many offenders who would have adaptive functioning impairments that were related to paucity of parental care or lack of a competent role model rather than learning disability. They may also have been institutionalised and so lost opportunities to develop adaptive functioning skills. This may be evident, for example, by an inability to maintain a housing tenancy through being unable to live independently or manage finances. Therefore a move to less supervised accommodation can be a daunting prospect for anyone who has been told when to get up, when to go to bed and when to have meals for many years.

MAPPA panels are often aware that offenders have serious impairments of adaptive functioning but are unable to secure appropriate support for these individuals. This may be because of uncertainty as to the causality of the impairment as described above. Some offenders have simply never been given the opportunity, or the teaching to be able to look after themselves properly.

### **Age of Onset within the Developmental Period before Adulthood**

One of the important distinctions made by diagnostic criteria, such as that outlined in the current DSM IV/5, is that the age of onset for learning disabilities should be in the developmental period before adulthood, below the age of 18. Hence intellectual impairment must be developmental. Despite the threshold of 18 years of age there is concern from some practitioners that people acquiring learning disabilities later in childhood as a result of brain injuries may present different challenges from someone who had shown learning disabilities from infancy, (BPS Professional

Affairs Board, 2000). This is a further example of the difficulties with defining intellectual disabilities. It is why the notion of causality must be taken into account during any assessment.

When offenders are estranged from their parents it can be difficult to obtain any accurate historical or developmental information. Hayes (2008) refers to the difficulty of establishing a diagnosis of intellectual disability in the CJS. She attributes this firstly to the difficulty in obtaining a complete and accurate health and development history, secondly to the involvement of offenders in both substance misuse and risk taking behaviours from an early age. Therefore it is difficult to ascertain whether any limitations were present during the developmental period or acquired later in life.

Similarly Barnfield and Leatham (1998) refer to the difficulty in establishing the aetiology of deficits in verbal memory and learning, abstract thinking, general memory and socialisation. Again they attribute the difficulty to high rates of traumatic brain injury, other brain damage and substance abuse.

## **Learning and Developmental Difficulties**

The term learning difficulties is also used to describe a range of difficulties including dyslexia, dyspraxia, and dyscalculia, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD), including Aspergers Syndrome. Albeit, DSM 5 (2013) distinguishes these into various diagnostic headings namely, Autism Spectrum

Disorder, Attention-Deficit/Hyperactivity Disorder and Specific Learning Disorder. These are described in more detail below.

## **Dyslexia**

Dyslexia is a learning difficulty which affects the development of reading skills. Many children with dyslexia may also struggle with some aspects of language development. Left undiagnosed and without support these problems may persist through adulthood. Some of the possible difficulties associated with dyslexia such as difficulty remembering written information, poor organisation or time management and misreading information which affects understanding may have significant consequences for offenders who are required to attend appointments at certain times or for offenders who are sent warning letters they do not understand. Rack (2005) found that offenders are 3 to 4 times more likely to have dyslexia than the general population. Albeit as with the questioning of some other diagnostic categories, the diagnosis of dyslexia has recently become contentious within psychology, (Elliot, 2014).

The issue of illiteracy and poor reading skills is prevalent amongst the offender population. In examining the issue of literacy more broadly, Snowling, Adams, Bowyer-Crane and Tobin (2000) studied levels of literacy among 91 young offenders. They reported that ‘as a group, juvenile offenders are best described as having general verbal deficits encompassing problems of language and literacy’ (pg. 229). Snowling et al (2000) experienced similar difficulties to previous studies in

separating out the effects of specific disorders from the difficult life experiences the group had such as poor school attendance and social and family adversity.

## **Dyspraxia**

Dyspraxia is difficulty with motor movement. Speech dyspraxia may present as individuals not being able to string together sounds and syllables to make coherent words or appearing frustrated and avoiding speaking. They may have associated gross or fine motor difficulties such as clumsiness or poor organisational skills. Again this would place someone in a vulnerable position within the CJS if they are unable to communicate clearly and become frustrated. As will be outlined in Brier's (1989) differential treatment hypothesis described later in the chapter, this inability to communicate clearly or to appear rude or frustrated, may attract a more punitive response from CJS professionals. Similarly the Care Services Improvement Partnership (Betts & Zammitt, 2007) Positive Practice, Positive Outcomes<sup>2</sup> noted that 'an inability to communicate is often regarded as non-compliance.'

Gregory & Bryan (2010) examined the incidence and severity of communication difficulties among young offenders. A speech and language therapist was seconded to a Youth Offending Service (YOS) to work with young offenders who were being managed by the Intensive Supervision and Surveillance (ISSP) team. This team managed offenders who had been sentenced to ISSP due to

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<sup>2</sup> Positive Practice, Positive Outcomes – A handbook for professionals in the criminal justice system working with offenders with a learning disability, Betts & Zammitt (2007)

persistent and prolific offending. Following screening 65% were identified as requiring speech and language intervention. Gregory and Bryan (2010) stated that ‘the communication difficulties identified were sufficient to prevent the young people from accessing the standard YOS interventions.’

## **Attention Deficit Hyperactivity Disorder**

The term Attention Deficit Hyperactivity Disorder (ADHD) refers to a range of problem behaviours associated with poor attention span. Such behaviours may include restlessness, impulsivity, and hyperactivity, interrupting others, difficulty keeping quiet and speaking out of turn, taking risks, extreme impatience or forgetfulness. These problems can often prevent children from learning and socialising well; they tend to persist into adulthood. Waschbusch (2002) found that children with both conduct problems and ADHD tend to have lower verbal IQ scores than controls, thus demonstrating that disrupted schooling can negatively impact on IQ scores. If not previously diagnosed then ADHD presentational issues could be misunderstood by CJS professionals who had not made appropriate allowances or adaptations.

Young and Goodwin (2010) examined ADHD in persistent criminal offenders and argue the need for specialist treatment programmes as due to the prevalence of ADHD as there are a ‘disproportionately high number of offenders with ADHD’ that are being managed within the Criminal Justice System in the UK. Young & Goodwin (2010) cite prevalence rates for ADHD of 45% of youth offenders and up to 30% of adult offenders. The researchers also criticise the Bradley

Report (2009) for failing to recognise ADHD as a mental health condition. Especially given the impact the disorder can have on an offender's ability to cope with and progress through the system. Lindsay, Carson, Holland, Taylor, O'Brien and Wheeler (2013) found that ADHD with conduct disorder was associated with a greater degree and history of problematic behaviour in offenders with intellectual disability.

## **Autistic Spectrum Disorder**

Autistic Spectrum Disorders (ASD)<sup>3</sup> and Aspergers Syndrome are developmental disorders. Those individuals with a higher IQ may be referred to as having high functioning Autism or Aspergers Syndrome. All individuals with ASD struggle with social interaction and communication to some extent. The triad of impairments refers to the three main areas of difficulty, social interaction, difficulties with communication and difficulties with imagination. People with ASD may be unable to read social cues, appear to lack empathy, behave in what may seem an inappropriate or odd manner, may avoid eye contact when under pressure or appear indifferent.

The second area is difficulties with communication which may include making a literal interpretation of figurative or metaphorical speech. Communication difficulties may also be present, the person using formal, stilted or pedantic language, having poor concentration and listening skills

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<sup>3</sup> Also referred to as Autistic Spectrum Conditions (ASC).

or becoming agitated in responses, or coming across as argumentative, stubborn, or even as over-compliant and agreeing to things that are not true.

Finally people with ASD have difficulties with imagination. This may present as the person having difficulty in foreseeing the consequences of their actions, becoming very anxious at any changes in routine and liking set rules and overreacting to other people's infringement of them. They may also have specialist interests which can become an obsession and may find it difficult to imagine or empathise with another person's point of view. Again these difficulties could be misinterpreted by CJS professionals who were unaware of the person's diagnosis.

O'Brien and Taylor et al (2010) found a prevalence rate of 10% of autistic spectrum disorder in their multi-centre study of adults with learning disabilities. They cite this as similar to the overall rate of ASD reported among adults with a learning disability who offend (e.g. O'Brien and Bell, 2004).

Given the prevalence and impact of learning difficulties on an offender's ability to progress successfully through the CJS it is useful that both Lord Bradley's (2009) report and Talbot's No One Knows (2007) report included learning difficulties in their inclusion criteria. The current study will seek to consider this aspect when delimiting the criteria for intellectual disabilities to be used.



## **The Relationship between Intellectual Disability and Offending Behaviour**

A number of studies have examined the relationship between low IQ, cognitive impairment, intellectual disabilities, intellectual difficulties and offending behaviour (Brier, 1989; Farrington & West, 1993; Lindsay & Taylor, 2010). The following section focuses on theoretical models of the link between ID and offending behaviour such as Farrington's longitudinal Cambridge study (1995) which identified the link between low school attainment and low IQ and delinquency or offending behaviour. The relevance of Developmental and Life Course theories of offending to the proposed study and Brier's (1989) three possible explanations of the link between learning disability and delinquency, to the proposed thesis are also discussed.

### **Developmental and Life Course Theories**

'Developmental and life-course (DLC) theories of offending integrate knowledge about 'individual, family, peer, school, neighbourhood, community, and situational influences on offending,' (Farrington, 2008, p. 1). DLC theories aim to explain offending by the individual rather than groups of offenders. The theory proposes that 'a small fraction of the population (the "chronic" offenders) commit a large fraction of all the crimes' (Farrington & West, 1993, pg. 5). Given the strong link between low intelligence scores and life-course-persistent offenders who start offending earlier and commit more and a greater diversity of crimes there is a need to focus on the needs and management of this group of offenders. Together with the findings from the recently published Bradley Report

(2009) and the No One Knows report, (Talbot, 2007) it would appear that offenders with intellectual disability or intellectual difficulty are in receipt of a poor service from the CJS in general.

## **Developmental Theory**

Moffitt's developmental taxonomy (1993) proposed two types of offender. The first group, adolescence-limited (AL), refers to the group of offenders whose offending behaviour is confined to their adolescent years. That is, the offending occurs within the context of peer delinquency so that this group 'grow out' of offending. The second group of offenders are described as life-course-persistent (LCP). This group begins their anti-social behaviour earlier, commits a greater variety of crimes and are unlikely to desist from criminal activity into adulthood. Piquero and Moffitt (2008) propose that the risk for 'life-course-persistent-offending emerges from inherited or acquired neuropsychological variation, initially manifested as subtle cognitive deficits, difficult temperament, or hyperactivity (p. 53).' Due to the infiltration of anti-social activities into adult life Moffitt also states that 'this infiltration diminishes the possibility of reform such that life-course-persistent-offenders have few (if any) opportunities to learn and practice pro-social behaviour and limited opportunities for change...'. Similarly, Piquero and Moffitt (2008) propose that the main motives and reasons for offending in LCP's originate in an interaction between neuropsychological problems and disadvantaged environments. During childhood discipline problems and academic failures accumulate and prevent opportunities to practice pro-social behaviour.

LCP offending is predicted by a number of individual risk factors including low intellectual abilities. Donnellan, Ge and Wenk (2000) tested the cognitive abilities of LCP and AL offenders. This research examined Moffitt's assertion that AL offenders would score higher on tests of cognitive ability. The research established partial support for the hypothesis, namely that this difference did exist for white American and Hispanic offenders but did not for African American offenders. Piquero and Moffitt (2004) cite evidence for numerous studies that demonstrate LCP offending does have the predicted neuro-developmental correlates as well demonstrating the importance of biosocial interaction.

### **Norman Brier's (1989) Review and Reappraisal of the Relationship between Learning Disability and Delinquency**

Brier (1989) proposed 3 main hypotheses in relation to offenders with intellectual disabilities. Firstly, the Susceptibility Hypothesis states that the neurological and intellectual difficulties of Learning Disability (LD) directly contribute to antisocial behaviour. This could be due to problems with conceptualisation, comprehension and judgement, and problems with social perception. Brier (1989) notes that impulsivity and attention are issues more closely related to Attention Deficit Hyperactivity Disorder (ADHD) but that ADHD is not necessarily associated with offending. Interestingly Farrington (1995) also draws parallels between offending and conduct disorder and yet the two are not inevitably related. In relation to this Brier (1989) specifically examined the subset of adolescents with ADHD and LD who are more likely to be delinquent. Those who were more delinquent appear to have a combination of LD, ADHD with 'aggressivity' (or aggressive

behaviour). Non aggressive non LD ADHD sufferers are no more likely than a 'normal' group to become delinquent. Therefore a diagnosis of ADHD alone would not raise the risk of delinquency but the addition of LD and aggressive behaviour would. A further link relates to those LD adolescents with language difficulties in that this group also seem more likely to become delinquent. The high risk profile for LD adolescents then appears to be as follows: language and social perception difficulties in interaction with inattentive, impulsive, and aggressive behaviour. The current research includes these items and investigates language and social perception difficulties in addition to inattentive, impulsive and aggressive behaviour.

Larson (1988) criticises the susceptibility hypothesis for not taking into account explanations other than ID for poor social skills and social judgement. She argues that the causality of negative social characteristics must be considered.

Brier's second hypothesis, the School Failure Hypothesis, suggests that the school failure experienced by LD adolescents is the first step on the route to delinquency, punctuated by experiences of criticism and rejection, development of negative self-image, increased frustration and dropping out of school. Given the close link between school failure and delinquency it is difficult to separate out the impact of LD. Larson (1988) argued that school failure is an effect, rather than a cause of social misbehaviour and delinquency for ID offenders.

However those with LD do tend to experience criticism and rejection from class mates and teachers (Dudley-Marling & Edmiston, 1985). Increased frustration is experienced if the individual had higher expectations made of them than could be met by their level of ability. As Piquero & Moffitt

(2008) hypothesised school failure or imprisonment leads to a reduction in pro-social opportunities. Therefore it could be argued that a delinquency-prone temperament is the product of repeated failure and reduced access to pro-social alternatives. In Crewe's (2007) examination of power, adaptation and resistance in a late-modern men's prison he considers the dynamics within prisons. Jones (2008) reflected upon Crewe's work in relation to her own research and stated 'furthermore their (LD prisoners) susceptibility to feelings of embarrassment, humiliation and of not being in control of either their current status or future prospects serves as a reminder about the capacity for frustration to lapse into non-compliance.' Jones (2008) observes that this may in turn attract labels such as difficult, disruptive and anti-authoritarian. Later in the chapter the effects of school exclusion on the offending careers of young people are explored. The current research will aim to capture data about school failure.

The third of Brier's hypotheses, the Differential Treatment Hypothesis, essentially asks whether adolescents with LD receive differential treatment from the Criminal Justice (CJ) Agencies. Specifically:

- 1) Are they more likely to be picked up by the Police for comparable delinquency?
- 2) Are they at greater risk of punishment than non-LD individuals?
- 3) Are they more likely to receive a more severe punishment than non-LD offenders?

Dunivant (1982) found that LD adolescents were 200% more likely to be arrested by the Police than non-LD for comparable crimes and they were more likely to be adjudicated than non LD adolescents. However no differences were found in the seriousness of sentencing. Brier (1989)

offers two possible explanations for this. Firstly, that LD delinquents lack strategies to avoid detection or effectively dissemble during interview and secondly, that the LD group may be more socially inappropriate and abrasive in their manner with CJ personnel and hence attract a more punitive response. He proposes that it is likely that the social skills deficits of LD individuals contribute to their differential treatment. Kavale and Forness (1996) conducted a meta-analysis of social skills deficits and learning disabilities. They examined 152 studies of students with learning disabilities and found that 75% of this group had social skills deficits that differentiated them from comparison samples.

The differential treatment hypothesis is evidenced by studies such as that by Broder, Dunivant, Smith and Sutton (1981) who found that despite self-reporting similar types of delinquent behaviour, LD youths were twice as likely to be adjudicated.

However the differential treatment hypothesis has been subject to criticism by Larson (1988). She notes methodological flaws in the Broder et al (1981) study, namely that the level and seriousness of the delinquent behaviour was not covered in the self-report measure. Therefore the evidence for the differential treatment hypothesis appears to be mixed, in that whilst there is some evidence that differential treatment takes place, there is less evidence for the reasons as to why this might occur.

## **Further Risk Factors Related to ID Offenders**

Two of the main individual risk factors for the early onset of offending before the age of 20 are low intelligence and low school attainment (Farrington, 2004). It is also the case that an early onset of offending predicts a longer criminal career with more offences committed. Therefore if there is awareness of this early predictor in an offender's history it should be taken into account during risk assessment and risk management. Lahey & Waldman (2007) in their psychological model of juvenile offending hypothesise that lower cognitive ability and slow language development also increase the risk for conduct problems. They refer to a range of constructs that have been used to refer to the cognitive deficits associated with conduct disorder including showing age inappropriate behaviours, verbal intelligence, language delays, neuropsychological dysfunction, and executive functioning. Lahey and Waldman (2007) also refer to the possible interactions between cognitive ability and some dispositional elements. They offer the example of children with lower cognitive abilities and delayed language often experiencing failure in tasks and games. If offenders are engaged in other types of anti-social behaviour such as substance misuse, alcohol misuse and fighting there is an increased likelihood of cognitive impairment and possibly issues with executive functioning. This impact on cognitive deficits would exacerbate many of the issues pertinent to conduct disorder mentioned above.

Winter, Holland and Collins (1997) conducted a study of people who had been arrested and charged at a Police station. They found that those people, who had attended special school in relation to a comparison group of ordinary school attendees, were more likely to have the following

characteristics; substance abuse, a family history of offending, psychosocial disadvantage, homelessness and mental health problems.

Lindsay and Taylor (2010) suggest that despite a long association between delinquency and low intellectual functioning it is still not clear whether people with ID commit more crime than non-ID offenders. They also describe further uncertainty as to whether the nature or frequency of offending by ID offenders differs from non-ID offenders (Holland, 2004).

Simpson and Hogg (2001) conducted a systematic review of patterns of offending among people with intellectual disability. They examined a variety of studies to identify the pre-disposing factors in the profile of offenders with ID. The two most powerful factors that were identified were similar to non-ID offenders, namely age and gender. Other factors identified by this study showed similar findings to that of Farrington (2004) and Lahey and Waldman (2007), that is: low socio-economic background, unemployment and behavioural problems.

O'Brien, Taylor, Lindsay, Holland, Carson, Steptoe, Price, Middleton and Wheeler (2010) conducted a multi-centre study of adults with learning disabilities examining the demographic, individual, offending and service characteristics of those referred to services for anti-social or offending behaviour. The study utilised a retrospective case note study design. They established the following characteristics;

- Mental health – 46% of referrals had presented with at least one psychiatric disorder in adulthood.



- Adult Physical Health Problems – 42% had a current major medical health problem requiring regular medical health treatment.
- Abuse and Neglect Experiences – 35% of participants had documented histories of child abuse or child neglect
- Anti-social and Offending Behaviour Characteristics – Many of the participants had high frequencies of offending or anti-social behaviours. 83% of cases had verbal and physical aggression as their index behaviour. The next most frequent behaviour was sexual offending (contact and non-contact) accounting for 29% of the sample. The researchers refer to low rates of theft, traffic-related offences, substance misuse related offences and fire setting.

More recently Fitzgerald, Gray, Taylor and Snowden (2011) have studied risk factors for recidivism in offenders with intellectual disabilities. The research examined whether the risk factors consistent with general offenders, mentally disordered offenders and ID offenders were also present in their cohort of ID offenders. They found that risk factors for ID offenders was broadly consistent with risk factors for the other groups, namely number of previous offences, number of previous acquisitive offences, number of previous drug offences and number of previous bail offences, as well as a history of substance abuse.

Clearly there is a complex relationship between intellectual disability and offending. It would appear that many of the pre-disposing factors for offending are the same between ID and non-ID offenders such as early onset, being male, behaviour problems, substance misuse and familial history of offending. It is also apparent that the nature and frequency of offending by ID may not differ from non-ID offenders. Therefore one of the many key areas still to examine is whether and how the ID

offender is treated differently within the CJS to the non-ID offender, as proposed by Brier's (1989) differential treatment hypothesis. The next issue considered is how many offenders may be affected by intellectual disabilities.

## **The Prevalence of Intellectual Disability in the Criminal Justice System**

Lindsay and Taylor (2010) suggest that the difficulties in establishing the prevalence rates for offenders with intellectual disabilities are due to several methodological issues. Firstly the difference in criminal justice settings in which research has taken place. Mason and Murphy (2002a) examined the prevalence of people with intellectual disabilities (ID) managed by probation. They found that 7% of their sample had possible learning disabilities based on the LIP's (Learning disabilities In the Probation Service) screening tool. There have also been a number of studies examining the prevalence of intellectual disabilities and intellectual difficulties among the offender population in prison. The prevalence rates vary from between 20 – 50% (Rack, 2005; Mottram, 2007). Mottram (2007) found that 7% of prisoners in England and Wales had an IQ under 70 and a further 25% had an IQ under 80. In a further paper, Brier (1989) cites prevalence rates ranging from 12% or less to 70% or greater. Brier attributes this wide variation to 'the use of differing, often imprecise definitions of learning disability, along with the use of differing assessment criteria, techniques and instruments'. Loucks (2007) found that 20-30% of offenders had learning disabilities or learning difficulties that interfered with their ability to cope within the criminal justice system. Other prevalence studies have focussed on aspects of the CJS other than prisons and probation, such as

high secure hospitals (Walker & McCabe, 1973), Courts (Messinger & Apfelburg, 1961) and police stations (Lyall, Holland, Collins & Styles, 1995).

At a more local level a needs analysis conducted on the prison population of the Kent and Medway area found that 7.2% of the sample obtained WASI<sup>4</sup> screening scores below 70 (Harding, Wildgoose, Beckley, Regan & Sheeran, 2008). A further 22% of the sample had screening IQ scores in the borderline range of 70-79. As acknowledged by the researchers the WASI is not a diagnostic tool but an IQ of below 80 would be indicative of the need for further assessment. Harding et al (2008) note that of the 78 participants who had an IQ score below 80 only 12 reported contact with mental health services. The research also utilised the Psychiatric Diagnostic Screening Questionnaire (PDSQ). When indications of psychiatric symptoms were combined with intellectual functioning further areas of unmet need were identified. Of the whole sample 14.77% warranted further assessment for both learning disability and mental health. Two thirds of this group reported no contact with mental health services. Indeed the study concluded that despite finding evidence for a higher prevalence rate of intellectual disability in Kent and Medway prisons than in the community 'there are currently almost no resources within the prison setting to screen prisoners' intellectual functioning, to offer full clinical assessment in this area, or to assess the level of need that such prisoners may have, or to ensure that provision is made to meet these needs.'

The second influence on prevalence rates that Lindsay & Taylor (2010) identify is methodological variation. This variance is no doubt due in part to differences in methodology and assessment but also the nature of the impairments being assessed. In relation to this Dunivant (1982) describes a

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<sup>4</sup> WASI – Weschler Adult Scale of Intelligence, 2 sub-test screening version. The WASI provides IQ scores which are analogous to the WAIS III (Weschler Adult Intelligence Scale 3<sup>rd</sup> edition).

large scale study undertaken by the National Centre for State Courts utilising large and representative samples and comprehensive assessments of intellectual disability and delinquency that found that 36% of imprisoned juveniles had an intellectual disability. The juveniles with ID were found to be twice as likely to have committed a delinquent offence compared to their non-intellectually disabled peers. These results were obtained when socio-economic status, family size and family interaction were controlled for.

The final influence Lindsay and Taylor (2010) cite is the inclusion criterion that is adopted. The inclusion of borderline cases, that is those offenders with an IQ between 70 and 79, significantly increases the prevalence rates. Some studies have used an IQ cut off of 80 or even 85 for intellectual disability. In a UK offender population, it is important to include those with an IQ under 80 as they are most likely to be disadvantaged by being unable to progress through meeting sentence planning targets. This is due to the fact that most offending behaviour programmes accredited by an expert committee<sup>5</sup> selected by the Ministry of Justice for England & Wales have exclusion criteria for those offenders with an IQ below 80. The inclusion criteria for this research and the rationale are discussed later in the chapter.

Mason and Murphy (2002b) outline the importance of ‘identifying individuals at risk of having intellectual disabilities, so that they can be provided with better support.’ The high prevalence rates of offenders who have low IQ and/or poor educational attainment is an important area for consideration in the forensic field. Similarly, Denkowski and Denkowski (1985) suggest that intellectually disabled offenders attract increased disciplinary measures when compared with the

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<sup>5</sup> CSAP – Correctional Services Accreditation Panel.

general population due to their inability to understand and comply with written and unwritten prison rules. Therefore it is important that support is provided to enable compliance with the rules and progress through the system. Otherwise this in turn would disadvantage them in the Parole process where generally little consideration is given to ID.

### **Paucity of Service for ID Offenders within the Criminal Justice System**

Throughout the Criminal Justice System there are numerous points at which an offender's intellectual disability could be identified and thus allow appropriate diversion, adaptation or support. However due to lack of resources, staff awareness and appropriate screening or assessment tools this is often not the case. The Bradley report (2009) followed the offender pathway from arrest through to sentence end. It was noted that the paucity of services was often linked to the lack of awareness of professionals and the lack of assessment. Similarly Harding et al's (2008) findings in the Kent prisons needs analysis noted the paucity of assessment resources for identification of intellectual disability or associated support needs or services.

Within the Criminal Justice System there is an over-reliance on screening procedures within the Police Custody Suite to 'divert' people away from the CJS to LD services. Initially a decision will be made by a Police Custody Sergeant as to whether someone requires assessment by a Custody Suite member of medical staff. They may then be seen by a nurse or medical practitioner who will make a decision as to whether the person requires diversion or additional support by an appropriate

adult<sup>6</sup>. Most custody sergeants are not trained in the identification of intellectual disability and so, many people then appear in Court unaware of what is happening to them. When passing through into custody or serving a community sentence they similarly may not understand. These issues are illustrated by Gudjonsson, Clare, Rutter and Pearse's (1993) study of persons at risk during interviews in police custody. On the basis of the researchers' clinical judgements, prevalence rates for mental illness were 7%, for learning disability they were 3% and for language problems 5%, therefore suggesting a need for an Appropriate Adult in 15% of cases; in contrast, the police called an Appropriate Adult in just 4% of cases.

Once in court it is dependent on the offender's Solicitor or the Judge or Magistrate in the case to identify whether someone is 'fit to plead.' Currently only about 100 cases a year result in fitness to plead being raised in the court. The rest are diverted prior to court or remain unidentified. Some good practice has developed around court based diversion schemes but these are by no means established nationally.

The next opportunity would be when an offender is seen by a member of the Probation service to be interviewed for a pre-sentence report. Then depending on the sentence they receive the next time an offender is assessed would be at reception to prison or at their first supervision session or induction if sentenced to a community order. Given the lack of availability of a consistent screening tool a lot of offenders unidentified at earlier stages will remain so.

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<sup>6</sup> The custody officer, in addition to having responsibility for all detained people and ensuring that interviews and other procedures are conducted as soon as possible and in the correct manner, must also ensure they identify vulnerable people. A vulnerable person is anyone who appears (to the custody officer) to be under the age of 17, people with mental health difficulties, people with a learning disability and those who have trouble communicating and understanding things. Having identified a vulnerable person the custody officer has a duty to request the attendance of a responsible adult, who is known as an Appropriate Adult. National Appropriate Adult Network site accessed 25/10/2010.

Even if an offender has been identified as having a learning disability or learning difficulty there remains a paucity of services appropriate to their needs. A Home Office Findings Report (page 233, 2004) stated 'As a result they are unable to progress through their sentence plan, which in turn may impact on parole dates and resettlement opportunities. Reducing re-offending is a central aim of the government's national strategy against crime; however, conventional offending behaviour programmes are not generally accessible for offenders with an IQ of below 80. There is a mismatch between the literacy demands of the group work and the skill level of offenders, which is particularly significant with respect to speaking and listening skills.' Where specialist groups are available, demand often outstrips supply. The No-One Knows report (Talbot, 2007) noted the lack of availability of the adapted sex offender programme.

There is a further consideration as to whether offending behaviour interventions are effective with this group of offenders even when adapted. Lindsay and Taylor (2010) reviewed a number of interventions with ID offenders. In respect of anger management they suggested that cognitive behavioural approaches can be effective with this population. Lindsay and Taylor also found evidence for the efficacy of psychologically informed and structured interventions in respect of sex offender treatment. Other offending and offence related interventions were examined such as fire-setting, cognitive skills and problem-solving. Lindsay and Taylor note that many studies researching the efficacy of such interventions have been small scale or pilot studies. However they conclude that there is some limited evidence to demonstrate that the 'treatment of criminal thinking styles' or problem solving interventions may be useful.

So it would be a matter of chance that an offender had been properly assessed and had his or her needs taken into account. This lack of appropriate assessment has recently been challenged in the Courts. Gill, R (on the application of) v Secretary of State for Justice (2010) EWHC 364 (Admin) was a case brought by a life sentence prisoner who suffers from a learning disability. Due to his learning disability he was unable to attend any offending behaviour programmes. As such he was unable to demonstrate a reduction in his risk and achievement of his sentence planning targets to bring about release. Due to this Mr. Gill served well over twice his tariff<sup>7</sup>. The Secretary of State was held in breach of the Disability Discrimination Act 1995 and a breach of the public law duties. Clearly there is a need for offenders to be assessed and treated appropriately to their needs.

### **Criteria for Intellectual Disabilities Used in the present thesis**

As outlined above it is clear that people with a diagnosis or description of learning disability, learning difficulty or intellectual disability are not a homogenous group. They are a group of individuals who may present with similar characteristics but different causality. However what they will have in common in the context of the CJS is a decreased ability to have their needs taken into account, in some instances to express themselves or to be understood.

In order to be as inclusive as possible the current research has sought to take into account both diagnostic criteria and broader inclusion criteria such as that described by the No One Knows study

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<sup>7</sup> A tariff is set by the sentencing Judge and is the minimum length of sentence a life sentenced prisoner must serve before being considered for release. More recently the tariff has been referred to as the 'minimum term.'



(Talbot, 2007). Large groups of offenders do not have their needs taken into account in spite of their cognitive functioning impacting on their ability to complete all objectives set in a sentence plan. As referred to earlier, the eligibility criteria for most CSAP accredited offending behaviour programmes is an IQ score of 80 or above. The main criterion of the current research is to collect data on those most disadvantaged in the CJS due to cognitive impairment. Therefore the definition for intellectual vulnerabilities in the context of this research is for the person to have two or more of the following issues:

Formalised diagnostic aspects such as IQ as measured by WAIS and WASI e.g. WAIS and WASI scores below 80 and WAIS score below 70;

Psychiatric and psychological diagnoses;

Historical issues such as statement of special educational needs (special school), previous contact with the learning disabilities team or supported housing.

To address the issue of causality information pertaining to head injury (traumatic brain injury), learning difficulties such as ADHD, ASD, substance misuse and mental health issues will also be obtained where possible.

Where this broader inclusion group has been used for comparison it has been named the Intellectually Vulnerable (IV) group and non IV group. Some of the analysis has utilised a stricter definition constructed from the psychological or psychiatric diagnosed ID, contact with the learning disabilities team or IQ score below 70. This more strictly defined group will be referred to as the Intellectual Disabilities (ID) group and compared with the non ID group.

## **Summary**

This chapter has outlined the relationship between intellectual disability and offending behaviour. The prevalence rates of intellectual disability have also been considered. Given the variation of prevalence rates the definitions of intellectual disability and various assessment criteria have been examined. Issues related to assessing significant impairment of intellectual functioning have been considered in addition to significant impairment of associated adaptive functioning. The age of onset within the developmental period before adulthood has been discussed with an outline of learning difficulties. The thesis criterion for intellectual disabilities was provided on the basis of the above. The paucity of appropriate services for ID offenders was summarised.

A further area for investigation as to the management of ID offenders is in Multi Agency Public Protection Panel Arrangements (MAPPA). The next section describes the MAPPA process in more detail. However broadly speaking the MAPPA process is the information sharing, risk assessment and management process conducted by the Probation, Police and Prison Services in conjunction with other related agencies such as housing and social services.

## **Chapter 2 - Multi Agency Public Protection Panel Arrangements and Intellectual Disability**

Multi Agency Public Protection Arrangements are the statutory arrangements for risk assessing and managing offenders in the community who present a high risk of sexual and/or violent harm. Currently there is no available data on the prevalence of offenders managed by this process who have intellectual disabilities. It is also unknown whether they are treated differentially and if so whether it is appropriate to their needs. Given that offenders managed by the MAPPA process are from the general offending population it is likely that prevalence rates will be broadly similar.

However in common with other elements of the CJS there are no national screening or assessment tools available to MAPPA panels. The Home Office MAPPA Guidance (2009) advocates the use of specialist risk assessments for offenders with mental health issues or intellectual disabilities. However it does not offer further guidance on what these assessments are or how they will inform management of the offender.

Similarly no further guidance is provided on the specific risk management strategies that would be relevant to ID offenders or on adaptations to ways of working. Therefore it is likely that offenders with ID managed by MAPPA may be treated more punitively as professionals rely more heavily on external controls to manage the individual.

The range of presentational issues described for learning disability and learning difficulties may also result in CJS professionals ascribing challenging behaviour to deliberate, intentional and negative motivations rather than correctly identifying the issues and managing accordingly. By then setting objectives that the offender can never hope to meet this may result in the setting up of offenders to fail as in the Gill case described earlier.

Given the lack of understanding of some CJS professionals of the mental health system it is unsurprising that the issue of ID is often pushed to one side. There is confusion between ASD, ADHD, Learning Disability and Learning Difficulty. There is also a lack of understanding between personality disorder and mental illness. Different Primary Care Trusts may structure their mental health and learning disability teams differently with varying inclusion criteria.

Therefore the current research is concerned with the prevalence, management and demographic and potential risk factors for offenders with intellectual disability/vulnerability managed by MAPPA.

## **Multi Agency Public Protection Arrangements - MAPPA**

### **History of MAPPA**

The National Probation Service has worked with other agencies such as the police for many years. This relationship became statutory in the Criminal Justice and Court Services Act 2000 (sections 67 and 68) when the police and probation service were given statutory responsibility for joint risk assessment and management of sexual and serious violent offenders through the creation of Multi Agency Public Protection Panels (MAPPP's). This led to the introduction of formal Multi Agency Public Protection Arrangements (MAPPA) created in April 2001.

The MAPPA have three 'responsible authorities' – the National Probation Service, the police and Her Majesty's Prison Service. In addition the Criminal Justice Act 2003 makes reference to the 'duty to co-operate'. This places responsibility on a number of other agencies such as health authorities and NHS trusts, housing authorities and registered social landlords, social services departments, social security and employment services departments, youth offending teams (YOT's), local education authorities and electronic monitoring providers to assist MAPPA by co-operation with the 'responsible authority.'

## **Offenders Managed by the MAPPA Process**

The Home Office MAPPA Guidance (Home Office, 2009) recommends that certain types of offender should be considered under MAPPA and if necessary risk managed by the process. There are three categories of offender considered under MAPPA. Category 1 offenders are registered sex offenders<sup>8</sup>. Category 2 offenders are violent offenders sentenced to 12 months custody or more and other sexual offenders. Category 3 are other dangerous offenders who, by reason of offences committed by them (wherever committed), are considered by the responsible authority to be persons who may cause serious harm to the public.

## **MAPPA Levels of Management**

In addition there are three levels of management dependent upon risk of harm and imminence of harm. Level 1 is ordinary agency management. Levels 2 and 3 are active multi-agency management. The three different levels enable resources to be deployed to manage identified risk in the most efficient and effective manner. Whilst there is a correlation between level of risk and level of MAPPA management (the higher the risk, the higher the level), the levels of risk do not equate directly to the levels of MAPPA management. The central question in determining the correct

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<sup>8</sup> The Sex Offender Register was introduced in the Sex Offenders Act 1997. It has subsequently been amended by the Criminal Justice and Court Services Act 2000. Offenders subject to the register must provide police with information of their name, address, DOB, national insurance number and vehicle details. They must inform the police within 3 days of any changes to these details. They must also inform the police at least 7 days in advance if they wish to leave the country for 3 days or more. They must also register any other addresses at which they spend more than a total of 7 days within any 365 day period. They must also confirm their registration annually. A failure to meet these requirements can result in a penalty of up to 5 years imprisonment.

MAPPA level is ‘what is the lowest level that a case can be managed at which provides a defensible Risk Management Plan?’ (Home Office, 2009). Therefore offenders may move between levels 2 and 3, dependent upon changes in dynamic risk factors. Level 3 MAPPA is used where active conferencing and senior management representation is required. Offenders managed at this level will usually have been assessed as presenting a 'high' or 'very high' risk of serious harm using the OASys (Offender Assessment System) risk and need assessment criteria. The case will be complex and may require a high level of resources or unusual resources at short notice. There may also be a high likelihood of media scrutiny. Kemshall et al (2005) in ‘Strengthening MAPPA’s’ suggests that ‘more provision may be needed for MAPPA offenders with mental health problems or intellectual disabilities.’ Despite this recommendation there is no further guidance within the MAPPA manual of what the additional provision may comprise.

### **Number of Offenders managed by MAPPA**

During 2008/2009 the total number of offenders in England and Wales managed by level 2 and level 3 MAPPA was 10924, (10,000 at level 2 and 924 at level 3). The South East region of England comprises of five areas: Kent, Hampshire, Surrey, Sussex and Thames Valley.<sup>9</sup> In this region the following numbers of offenders were managed at level 2 and 3 MAPPA:

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<sup>9</sup> During the course of the research Surrey and Sussex Probation Areas merged into the Surrey and Sussex Probation Trust.

**Table 2.1 Number of Offenders Managed by Level 2 and 3 MAPPA in the South East of England in 2008/2009**

<b>Area</b>	<b>Level 2</b>	<b>Level 3</b>
<b>Kent</b>	427	30
<b>Hampshire</b>	308	14
<b>Surrey</b>	132	6
<b>Sussex</b>	111	15
<b>Thames Valley</b>	347	20
<b>Total</b>	1325	85

Therefore within the South East during 2008/09 there were 1410 offenders within the scope of the study.

## **MAPPA Meetings**

The MAPPA Guidance version 3 (2009) outlines the functions of MAPPA meetings on level 2 and 3 offenders, namely to share information, to use this information to inform risk assessment and to formulate a risk management plan based on the risk assessment. The risk assessment should focus on the likelihood of re-offending; identify risk of serious harm to whom and in what context, and to consider the imminence of offending behaviour.



In terms of attendees, there should always be Probation and Police Service representation. At a level 2 meeting this should be at least Senior Probation Officer and Inspector/Chief Inspector level. At level 3 meetings this should be at least an Assistant Chief Probation Officer and Basic Command Unit Commander/Superintendent. Other standing members may include – Social Services, Health Services and Housing. If the offender is still in custody (an offender should be considered at least 6 months before release) then a Prison Service representative should attend. Similarly Victim Liaison Officers should attend where they are actively involved with the victim or victim's family.

There is a standing agenda which should be followed at all MAPPA meetings (Home Office, 2009), see Appendix A. Firstly the Chair carries out introductions and notes any apologies. This is followed by reading the confidentiality statement. The Chair will then either read out or ask the Offender Manager to read out information about the offender and note their legal and MAPPA status. Information sharing, Risk to Victims, Diversity Considerations, Risk Assessment Summary of risk factors, Disclosure decision, Communication; media and press handling, MAPPA risk management decision and plan, Human Rights Act validation, update to ViSOR<sup>10</sup>, Issues for reporting to the MAPPA Senior Management Board (SMB) and Review meeting date.

One of the main sources of data for the research is the minutes taken from the MAPPA meetings. Again the minutes follow a template set in the MAPPA Guidance (2009), see Appendix B. The minutes record the following information; Introduction by Chair which records who chaired the meeting. The confidentiality statement is recorded next with guidance on what and how information

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<sup>10</sup> ViSOR – Violent and Sex Offender Register database. The ViSOR database was introduced to hold information that could be accessed by all Police forces following the Ian Huntley case. All risk information and description of offenders who are on the register are held on this database. The Probation and Prison Service have limited access to ViSOR and can copy relevant records across to the database.

is to be shared and stored. It also outlines the legislation that underpins the meeting and sharing of relevant information.

The Offender Information section of the minutes gives brief demographic information about the offender such as name, date of birth, ethnicity, ViSOR reference number and some brief details of the date, time and place of the meeting. The next section lists attendee introductions and apologies. Section 5 records the legal and MAPPA status of the offender such as sentence, orders and MAPPA category. The next section gives a summary of referral information.

Section 7 records the additional information from other agencies. This generally starts with a review of the previous action plan if the offender has been reviewed before. Some areas then record discussions verbatim whereas others record only relevant, key points. Section 8 records the risk to victims which may be named individuals and/or particular groups at risk such as children or staff. Section 9 is diversity considerations which record any discussions around offenders individuals needs such as age or disability, that need to be taken into consideration. The risk assessment summary lists risk factors relevant to the individual and may also include restrictive, rehabilitative and re-integrative measures. Section 11 records the discussions regarding any decisions to disclose information about the offender to outside agencies or individuals such as schools or leisure centres. Section 12 of the minutes outlines any communication issues likely to arise with media interest in a particular case.

Section 13 is the MAPPA Risk Management decision and Plan which is described in more detail in the next paragraph. Section 14 is the Human Rights Act validation which records the meeting

participant's agreement that the meeting was justifiable, appropriate, proportionate, auditable and necessary in relation to the risk presented by the offender. Section 15 is the update to the ViSOR database. Section 16 records any issues for reporting to the MAPPA Senior Management Board (SMB) which is comprised of senior representatives from relevant agencies. Finally section 17 records the date, time and location for the next review meeting.

The Risk Management Decision and Plan referred to in section 13 is sent out as a separate document to all attendees at the meeting within 24 hours of the meeting. The plan details what action is to be taken by whom and by when. This section of the meeting must also consider the level of risk of harm the offender poses which can be low, medium, high or very high. This decision is reviewed every meeting.

## **Role of Other Agencies**

In addition to the responsible authority the 'duty to cooperate' agencies also attend relevant MAPPA meetings. These agencies may include representatives from health authorities and NHS trusts, housing authorities and registered social landlords, social services departments, social security and employment services departments, youth offending teams (YOT's), local education authorities and electronic monitoring providers. All agencies are required to share relevant information about the offender to contribute to the risk assessment and management process.

The presence of mental health professionals or learning disability specialists could be deemed to have a positive influence on the discussions and decisions of the MAPPA meeting when considering an offender with ID. However as referred to above the configuration of mental health teams and learning disability services varies from area to area. The research will also consider the relevance of the configuration of LD services and MH teams in each of the areas covered where possible.

### **Efficacy of MAPPA**

MAPPA is a very complex process, involving numerous agencies. As such determining what constitutes a successful outcome with regard to MAPPA is difficult. As Kemshall (2003) notes, “the absence of disaster is not enough as an evaluation strategy”. Wood, Kemshall, Maguire, Hudson and Mackenzie (2006) observed that defining effectiveness in the context of MAPPA is difficult to clarify and measure, especially determining “what flows from joint MAPPA partnerships and what stems from individual agency responsibilities”. The problem lies in the difficulty of trying to demonstrate conclusively that some individuals do not re-offend because of the risk management strategies in place.

One key outcome that could be deemed a measure of efficacy is the rate of re-offending committed by those offenders managed by the process. For the past four years the rate of serious re-offending by offenders managed by MAPPA has remained around 0.5% per year (Home Office, 2009).

The way in which the rate of serious offending is measured is via the Serious Further Offence (SFO) process. A serious further offence is defined in Probation Circular 22 of 2008. Essentially it includes homicide or attempted homicide, rape or attempted rape and other serious violent or sexual offences with a maximum penalty of 14 years' imprisonment or more. The following data only relates to those offenders who are charged with an SFO whilst managed at level 2 or 3 of MAPPA. In 2008/9 only 40 out of the 10000 offenders managed at level 2 committed a serious further offence (0.37%). Of the 924 offenders managed at level 3 only 8 committed a serious further offence (0.9%). This compares favourably to the most recent adult general reconviction rate of 40.1% (Home Office, 2010). Clearly the general adult reconviction rate will be higher as all offences are included and not all of this group are subject to MAPPA. However this may suggest that properly directing resources to manage risk i.e. MAPPA, results in far less serious reconvictions.

Wood et al (2006) found that MAPPA contributed effectively to both the community supervision and management of sex offenders. Participants in the research identified the most helpful factors as increased accountability, interagency working and access to key resources. Wood et al (2006) noted a focus on external controls such as licence conditions, behavioural restrictions, use of Police home visits and contact restrictions. They also noted the importance of offenders being able to develop internal controls i.e. the offenders' ability to recognise and manage risky situations and triggers. Offending behaviour programmes were described as one of the ways to achieve this in addition to effective supervision by the Probation Officer. Lord Bradley (2009) also acknowledged the difficulty for those offenders with mental health or learning disabilities of keeping to the conditions of orders such as ASBO's (Anti-Social Behaviour Orders).

Therefore effective outcomes for offenders with ID managed by the MAPPA process would involve a balance between external and internal controls. The research will aim to consider whether ID offenders are managed with significantly higher levels of external controls than non ID offenders.

### **Relevance of MAPPA to current research**

Level 3 and to some extent level 2 MAPPA manage the ‘critical few’ offenders in order to reduce re-offending. Therefore there is value in identifying the psychological risk and protective factors for offenders managed by this process, in particular offenders with Intellectual Disability. Developmental and Life Course (DLC) theories of offending have examined offender typologies. Farrington and West (1993) state that: ‘a small fraction of the population (the “chronic” offenders) commits a large fraction of all the crimes’. This would support the importance of learning more about this group of offenders as they cause a disproportionate amount of harm.

Similarly, Piquero and Moffitt (2008) propose that the main motives and reasons for offending in LCP’s originate in an interaction between neuropsychological problems and disadvantaged environments. During childhood discipline problems and academic failures accumulate and prevent opportunities to practice pro-social behaviour. Therefore it could be argued that MAPPA risk management plans should have a greater focus on providing opportunities to practice pro-social behaviour akin to the ‘Good Lives’ model proposed by Ward and Stewart (2002). That is a greater focus on the non-offending aspects of an offender’s life (the goods) as opposed to an intervention

focusing purely on the negatives (offending). Therefore it is of interest to investigate whether risk management plans are advocating purely external controls rather than advocating pro-social opportunities.

Lahey and Waldman (2007) also refer to the possible interactions between cognitive ability and some dispositional elements. They offer the example of children with lower cognitive abilities and delayed language often experiencing failure in tasks and games. During adulthood this may manifest in the MAPPA context as offenders with lower cognitive abilities being unable to achieve the sentence planning objectives or licence conditions asked of them. This may mean that ID offenders managed by MAPPA are being inadvertently set up to fail, as in the Gill case.

It is also important to consider the presentational traits of the offenders managed by MAPPA and what these may be attributable to. As discussed earlier in chapter 1 there can be significant overlap and similarity in diagnoses such as dysexecutive syndrome and anti-social personality disorder, drawing into question how clinically useful such diagnostic criteria are. These include impulsivity, lack of empathy, failure to inhibit, a lack of self perception, affective instability, aggression, disproportionate rage and suspiciousness, (American Psychiatric Association, 2000). Similarly Traumatic Brain Injury (TBI) can often cause impulsivity and a lack of affective empathy. Such traits have often featured in the description of persistent offenders (Jolliffe & Farrington, 2003). These are traits that would be evident in a number of offenders, especially those managed by the MAPPA process. Thus the causality of the traits would be important to consider. Staff ascribing negative and deliberate causality to behaviour may be more likely to treat an offender punitively than if they understand the traits to be associated with ID or TBI.

As discussed earlier in the chapter assessment methods are underutilised and frequently offenders with ID have remained unidentified. This is in part due to a lack of appropriate staff resources to undertake assessments. However there are also methodological issues to take into account. For example, when measuring age of onset there can be significant difficulties in obtaining a reliable and detailed developmental account. It is unfortunate the childhood records of the vast majority of offenders are not available to MAPPA panels and therefore the age of onset of any difficulties is not known. Similarly due to the familial breakdown issues so prevalent in the offender population it is often difficult to identify a parent or carer who could act as a 'reliable informant' that is required for some assessments.

Other features of ID may also exacerbate difficulties that MAPPA panels already have such as finding appropriate accommodation. Adaptive functioning impairments may impact on offender's ability to live independently. Frequently offenders managed by the MAPPA process are required to move to approved premises when they are released from prison. Approved premises which are predominantly owned and run by Probation Trusts are staffed 24 hours a day. There is a high level of security and support. However move on accommodation is very difficult to find, especially for offenders with ID. If this group are placed in Approved Premises there are understandable concerns about their level of vulnerability from other residents and indeed the risks they present to other residents if placed in ID supported housing.

The lack of suitable provision for this group is of concern and an area that warrants further investigation, particularly in the context of MAPPA where extensive external controls may be placed on individuals managed by the process. Thus the aim of the research is to investigate the



prevalence of offenders with intellectual disabilities and whether they are managed differentially by MAPPA to non-ID offenders, such as the level of external control.

## **Summary**

The Multi Agency Public Protection Arrangements have been fully described, including the history of MAPPA, efficacy of the process in managing high risk offenders and the population managed by the process. The chapter then outlined the issues in relation to managing offenders with ID within MAPPA and relevance of the MAPPA population to the study.

## **Chapter 3 - The Current Study**

### **Aims, Objectives and Hypotheses**

The overall aim of the research is to contribute to knowledge about offenders with intellectual disability or vulnerability in the Criminal Justice System, particularly in relation to prevalence, differential treatment and demographic and potential risk factors. It is anticipated that this research will be used to inform the assessment and management of offenders with intellectual disability/vulnerability by the National Probation Service. Whilst offenders with intellectual disability is an area that has been researched in specific contexts such as high security hospital, prisons and probation there has not been any research relating to offenders with intellectual disabilities who have been assessed as high risk of re-offending and of harming others. It is important to understand whether the needs of this group are being obscured by a total focus on risk rather than balancing this with an assessment of need.

There is also little adequate research on offenders managed under MAPPA (Wood, 2007a). This is an area in which offenders may be subject to highly restrictive external controls. For example sentence plans may contain objectives which an offender has to achieve to progress through the system. Similarly on release, licence conditions (see below for examples) may be complex and difficult to achieve, in particular for offenders with ID. Therefore the CJS in addition to not properly identifying this group of offenders in the first place may well be setting them up to fail.

The research is comprised of two main components, divided into study one and study two. Study one focuses on three main areas of investigation which are as follows; prevalence, differential treatment and key factors for ID offenders managed by MAPPA. Study two focuses on the central issues relating to ID offenders managed by MAPPA by examining the discourse within the MAPPA minutes.

## **Study One – Prevalence, Differential Treatment and Key ID Factors**

### **Prevalence**

The prevalence of offenders with ID has been calculated in many different ways as outlined in the above ‘prevalence of intellectual disability in the CJS’ section. Rates can depend on the criteria and assessment methodology used. Variation is also observed depending on the context in which the offender is situated. One area that has not been explored is offenders who have been assessed as high risk of harm. Therefore a key objective of this research is to identify how many high risk of harm offenders, managed by the most robust risk management, levels 2 and 3 of MAPPA, are identified as having ID/IV.

## **Differential Treatment**

Brier (1989) developed a number of hypotheses about juvenile offenders with ID. One of these was the differential treatment hypothesis. An objective of this research is to identify whether offenders with ID/IV are treated differentially. Namely are ID/IV offenders managed more punitively than non-ID/IV offenders? This will be measured by comparing the degree of external controls placed on the ID/IV and non-ID/IV offender groups, by number of licence conditions, Criminal Justice Act (CJA) requirements they have and the number of additional police led orders such as SOPO's (Sex Offender Prevention Orders).

## **Key Factors**

A number of researchers such as O'Brien et al (2010) and Fitzgerald et al (2011) have sought to identify demographic or potential risk factors for offenders with ID. A further objective of this research will be to identify whether the demographic and risk characteristics identified in previous research such as mental health, abuse and neglect experiences, suicide and self-injury and substance misuse are also present in the ID/IV cohort to a greater extent than the non-ID/IV cohort.

## **Study One – Hypotheses**

The following hypotheses will be investigated;

Experimental Hypothesis 1 (H1) - The prevalence rate for high risk of harm ID/IV offenders will be in the range of 20-30% in line with the Loucks (2007) criteria used by the Prison Reform Trust.

Experimental Hypothesis 2 (H2) - Offenders identified as having ID/IV (defined as having two or more of the indicators listed in the CRF) will have significantly higher levels of external controls than the non-ID/IV group.

Experimental Hypothesis 3 (H3) - The ID/IV group of offenders will have higher levels of key factors such as school disruption, mental health concerns, substance misuse than the non-ID/IV group.

## **Study Two – ID/IV Offenders; the Central Issues**

Given the complexity of intellectual disabilities and the issues around definitions and diagnoses, study two focused on a thematic analysis of the MAPPA minutes relating to offenders with ID/IV.

The question ‘what are the discourses around ID/IV?’ would provide the basis for an examination of the MAPPA minutes. The qualitative data gathered would also provide additional contextualizing

information to the quantitative analyses on prevalence, differential treatment and key factors, namely demographic and potential risk factors.

## **Chapter 4 - Methodology**

### **The Research Study – Differences between ID/IV and non-ID/IV**

#### **Groups**

This chapter outlines the sampling procedure, ethical approval, participant characteristics, research design and overall methodology of the research study. The research had two main components which will be referred to as Study One and Study Two. Study One focused on the quantitative data collected to undertake the analyses to test the three hypotheses based on prevalence, differential treatment and key factors. This will be described in more detail in Chapter 5. Study Two which will be outlined in further detail in Chapter 6, focused on the qualitative data collection and thematic analysis.

This research was undertaken to examine the prevalence of offenders with intellectual disabilities/vulnerabilities, test Brier's (1989) differential treatment hypothesis, examine key factors relating to ID/IV and consider the discourse about offenders with ID/IV. In this instance a community sample of those high risk of harm offenders who are managed by the Multi-Agency Public Protection Arrangements (MAPPA). Data were collected from MAPPA case files held at Probation and Police offices in the South East region.

## **Sampling Procedures**

The target groups were offenders managed at level 3 MAPP and level 2 MAPP in the Probation South East region. All offenders managed at level 3 MAPP were included as each Probation Area only managed between 0 and 15 level 3 cases. Many more offenders were managed at level 2 MAPPA. Therefore one local office from each Probation Area was selected on a quota sampling basis to create a representative sample from the level 2 MAPPA group. The sample recruitment process is outlined in the data collection schedule, see Appendix C.

As an indication of potential sample size, Kent MAPPA managed 49 offenders at Level 3 and 454 offenders at Level 2 in 2006/2007 financial year. An adjustment in the inclusion criteria for management levels initiated by the 3<sup>rd</sup> edition of the MAPPA guidance being published in 2009 means that there were 31 cases managed at level 3 in Kent in December 2009. Fifteen of these cases were managed in the community or due for imminent release and sixteen were either in prison custody or High Security Psychiatric hospital. In order to create a representative sample of level 3 MAPPA cases all active level 3 MAPPA cases in the South East Probation region were included in the study.

MAPPA Level 2 cases were also included to ensure that there was a large enough sample to allow effective comparison of ID/IV and non-ID/IV cases. Level 2 cases varied in number according to how strictly the MAPPA criteria had been applied and how much high risk, serious offending had occurred in the area. It could be argued that the level 2 caseload would not differ greatly from the level 3 caseload in terms of characteristics other than the level of imminence or resources required.



Indeed some cases are only deemed level 3 by virtue of their high media profile. The issue of consistency within MAPPA risk management is an area that could warrant further research.

To ensure a representative sample all the offenders managed at level 2 MAPPA local probation and police office bases were selected for each Probation Area as follows;

Surrey Probation Area –	Redhill
Sussex Probation Area –	West Downs, East Downs, Brighton & Hove, North Downs
Thames Valley Probation Area –	Reading
Hampshire Probation Area –	Aldershot
Kent –	Maidstone, Tunbridge Wells

Between 30 – 60 level 2 cases were recorded from each area. Hence all level 2's were included from Sussex and Surrey. There were no level 3 cases in Surrey during initial data collection.

## Consultation Process

At the time of the study there were 42 Probation Areas in England and Wales and there are 5 Probation Areas in the South East Region.<sup>11</sup> The South Eastern Region Probation Areas are Kent, Surrey, Sussex, Thames Valley and Hampshire. Each of the Probation Areas has a MAPPA Chair

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<sup>11</sup> During the course of the research several Probation Areas merged into larger Trusts. At the end of 2011 there were 35 Probation Trusts in England; Wales became a single Trust. Surrey and Sussex Probation Areas had merged into Surrey and Sussex Probation Trust. By June 2014 all Trusts had been dissolved and merged into one National Probation Service responsible for the management of all high and very high risk of harm offenders.

from Police and Probation. There is also a Director in each Probation Area that has responsibility for MAPPA.

Initially the research proposal as a written briefing document was presented at the South East Public Protection Forum (SEPPF), by the Kent Director. This is a quarterly meeting attended by the Directors of Probation who have responsibility for MAPPA in their Probation Area. The MAPPA Chairs/coordinators also attend. Following the presentation of an initial briefing the researcher was asked to present at the next meeting. The research proposal was presented and permission was granted for the research to proceed, once ethical approval had been obtained from Roehampton University Ethics Board. The SEPPF requested periodic updates on the research project. Each Probation Area nominated a key contact who could facilitate the researcher's attendance and file access at their MAPPA unit.

## **Ethical Considerations**

In order to gain consent for MAPPA case files to be examined a briefing sheet about the broad aims of the research was developed for the Kent Probation Assistant Chief Officer and Public Protection Manager to take to the South East Public Protection Forum as described above. At the meeting support was given for the study, however concern was voiced about whether there were sufficient cases i.e. offenders with ID/IV that would fall within the scope of the research. Therefore contact was made via e-mail from the researcher to the MAPPA leads in the five Probation Areas offering further details about the research. A request was also made as to whether an area would be willing to

facilitate a pilot study. Thames Valley Probation Area gave permission for the researcher to undertake a pilot study as outlined below.

Ethical approval was sought from all participating Probation Areas as well as from Roehampton University. All areas were advised of their rights to comment upon, withdraw consent from, and be informed of the final report and to have access to it. The Health and Care Professions Council (HCPC) standards of conduct, performance and ethics (2008) refer to the confidentiality of service users. MAPPA areas were requested to give their permission in writing for access to MAPPA files. This satisfied the HCPC requirement of 'for purposes where that person has given you specific permission to use the information.' In order to achieve the informed consent of MAPPA areas the research was explained and opportunity to raise questions or ask further questions was provided.

Information was also given with regards to accurate record keeping and secure data storage as follows: 'Consideration was given to confidentiality and secure data storage. In the research each case will be coded so that it may only be identified by the researcher. The key to the coding will be kept separately and securely locked in a filing cabinet. All data will be stored securely via the encrypted Probation server and data stick. All paper based information will be stored in a locked filing cabinet with identifying coding information kept separately from the data. The anonymity and confidentiality of participant's data will be ensured at all times in order to meet the British Psychological Society's (2006, 2009) ethical standard of privacy and confidentiality. Data will be securely destroyed after a period of six years.

All five Probation Areas were asked to give permission and ethical approval for the research in writing on headed paper and by signing the Roehampton University consent form, please see Appendix D for an anonymous example of the consent form and Appendix E for two anonymous examples of letters of permission to conduct the research from MAPPA Leads.

Following receipt of all the signed ethical approval forms the researcher visited all of the relevant MAPPA units in the South East region. A stand alone laptop computer was used in conjunction with an encrypted memory stick. The data were extracted from MAPPA files using the case review framework data file on SPSS (Statistical Package for the Social Sciences computer package) and a free text sheet for each case in a word document. Missing data were followed up via the MAPPA representative nominated for each MAPPA Unit. All data were backed up onto the secure Kent Probation server saved under the researchers' individual directory which was not accessible to other staff. All paperwork relating to the study was kept in a locked filing cabinet in the researchers' office which is not accessible to offenders or the general public. In order to provide a reliability check a random sample of cases were double checked by a second researcher in order to ensure consistency and quality in applying the Case Review Framework (CRF). The CRF is described in more detail in the methodology section for Study One in Chapter 5.

## **Pilot Study**

The CRF was initially pre-tested via a small pilot study in Thames Valley Probation Area, consent having been given by the MAPPA Manager. The pilot study enabled testing of the framework to ensure all relevant data were being captured and to assess prevalence rates of offenders with ID in

another area. In relation to prevalence rates, of the four cases studied, two offenders had two or more of the ID indicators. The pilot study revealed that Thames Valley MAPPA minutes are set out differently to those in Kent prior to the revised MAPPA guidance being issued. Therefore in some cases pertinent information was being recorded in different ways. In order to allow for anomalies, free text boxes were included to capture qualitative data not adequately captured by the coded items. This included the recording of MAPPA risk factors and risk management plans.

## Participants

The following section describes the participants that were used for both studies. The demographic information is covered in detail, in addition to providing the description of how cases were allocated to the ID/IV and non-ID/IV groups. The results for studies one and two are described in chapters 5 and 6.

Data were collected on 250 cases. Those included in the sample were aged from 15<sup>12</sup> to 70 years of age. There were 9 women and 241 men. In relation to ethnicity the majority (227) were white, 8 were black, 7 were mixed race, 5 were Asian, 2 were other and 1 person chose not to identify their ethnicity.

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<sup>12</sup> Probation Trusts manage people aged 18 and over other than 17 year olds who have received a Community Payback sentence. Those aged under 18 years are managed by Youth Offending Teams (YOT's). YOT's may refer very high risk of harm cases to the local MAPPA panel, hence the inclusion of some younger people in the sample.

All participants were people who had been convicted of criminal offences and as a result were being managed by a Probation Area or Trust in the South East region of England. They were all being managed either in custody or in the community by MAPPA at level 2 or 3.

In relation to whether the case was deemed to have an Intellectual Vulnerability (IV) or not, 186 were non-IV and 64 met the research IV criteria (the case had two or more IV indicators). For the sake of clarity specific details of the allocation of participants to the IV group are described here. This IV group was used for both studies.

The research used a number of indicators for IV as follows: file evidence of psychiatric diagnosis of intellectual disability, psychological diagnosis, cognitive impairment, head injury, brain damage, attendance at special school, school failure, supported living arrangements, WAIS score under 80 and 70, WASI score under 80 and 70, engagement with an ID team and an ID other category to capture any ID information not relating to previous categories. The reasoning for making IV operational in this way was to try and include all those offenders who may be disadvantaged in the CJS as indicated by Loucks (2007) and Talbot (2007).

As the studies discussed earlier have indicated, many offenders with IV may not have been identified. Even if they have been identified they may still be disadvantaged for example by having an IQ score under 80 but over 70 so that even though they do not meet the criteria for a formal diagnosis of learning or intellectual disability, such as that described in DSM IV/V, they are still excluded from areas of the CJS regime such as offending behaviour interventions and other

opportunities to progress through their sentence. As discussed earlier, in chapter 1, measures such as IQ scores are also not exact; scoring will only indicate the probability of a score falling within a specified range. Therefore by using two or more of the indicators to include a participant as IV there was a stronger probability of them being IV than on the basis of IQ score alone.

In order to consider the differences between Intellectually Disabled (ID) and non-ID groups more stringent criteria was used namely that the participant had a psychological or psychiatric diagnosis of ID, had contact with the community ID team or an IQ score below 70. There were 21 participants in the ID group and 229 participants in the non-ID group.

In relation to identifying the IV cases, of the IV criteria used the most prevalent categories and whether they were present is outlined below in table 4.1. Some of these variables were also present in the non-IV group as for this study IV group members had to have 2 or more IV variables. The methodological issues raised by these frequencies are covered in more detail in the discussion in chapter 7.

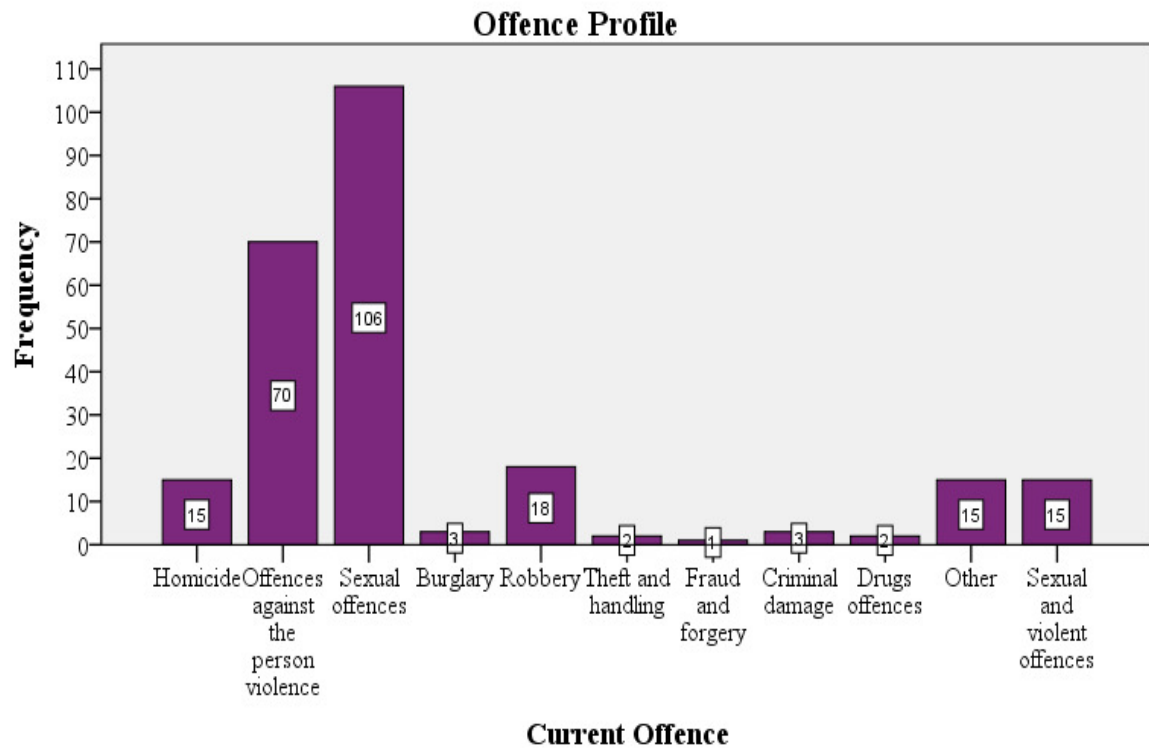
**Table 4.1 Frequency of IV Variables for the IV and Non-IV Groups**

<b>IV Variable</b>	<b>Total number of cases</b>	<b>IV</b>	<b>Non-IV</b>
Evidence of disrupted schooling	79	50	29
ID Noted in Diversity Considerations	52	48	4
Indicator of IV from file other than specified categories	50	47	3
File indication of cognitive impairment	32	23	9
File indication of Special Schooling	25	22	3
File indication of Head Injury	21	13	8
IQ score under 80	14	14	0
Indication ever engaged with LD Team	12	12	0
Autistic Spectrum Disorder	11	9	2
File Indication of Brain Damage	11	7	4
Psychological reference to ID	9	9	0
Evidence of supported living placement	9	8	1
IQ score under 70	4	4	0
Psychiatric reference to ID	4	4	0

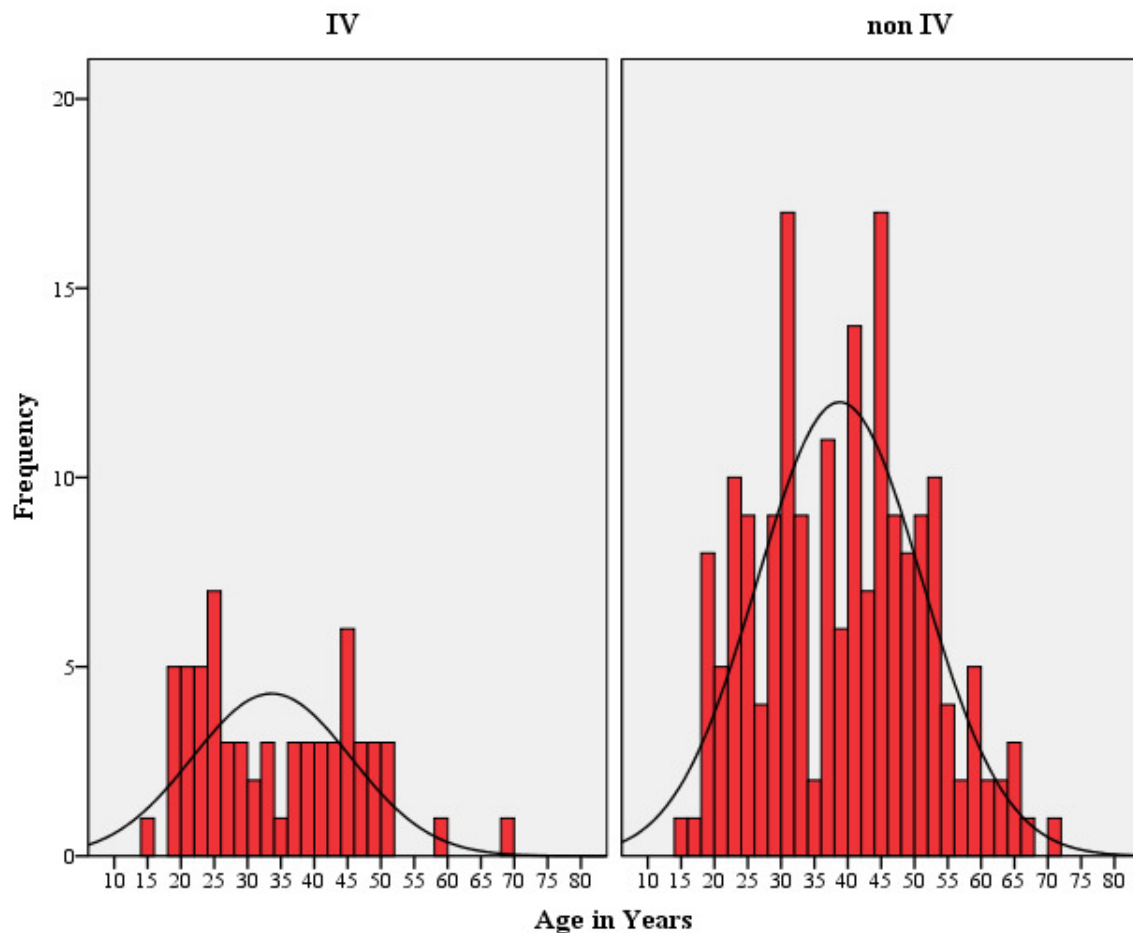


The following figure 4.1 outlines the offence profile of the whole sample.

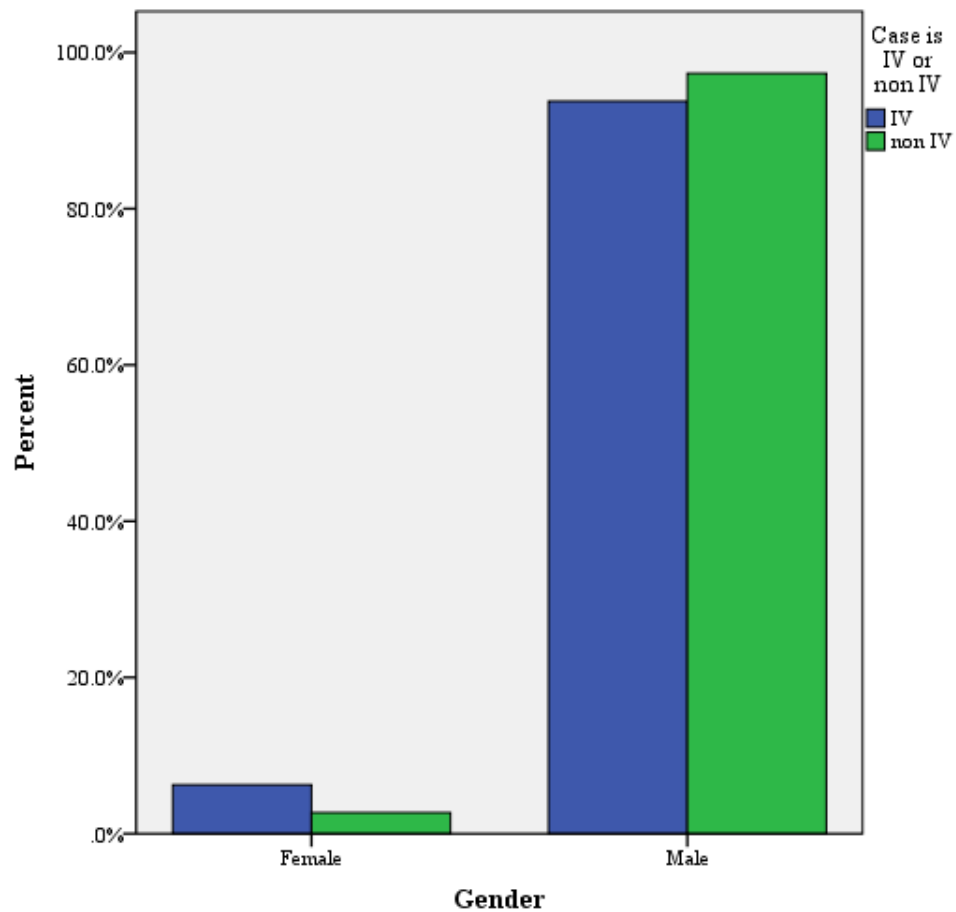
**Figure 4.1 Bar Chart illustrating the Current Most Serious Offence Profile of the Sample**



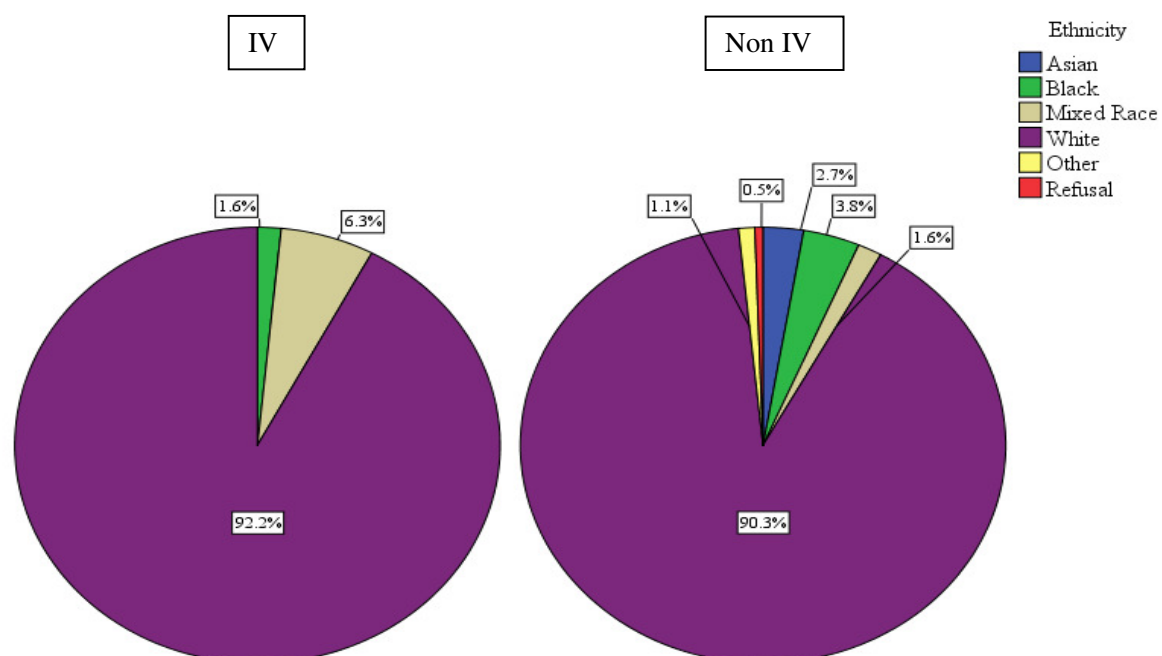
In order to explore differences in the data that may be associated with confounding variables such as age, gender, offence type and sentence length once the data file was split into non-IV and IV the output was compared as follows:

**Figure 4.2 Histogram Representing the IV and non-IV Sample Age in Years**

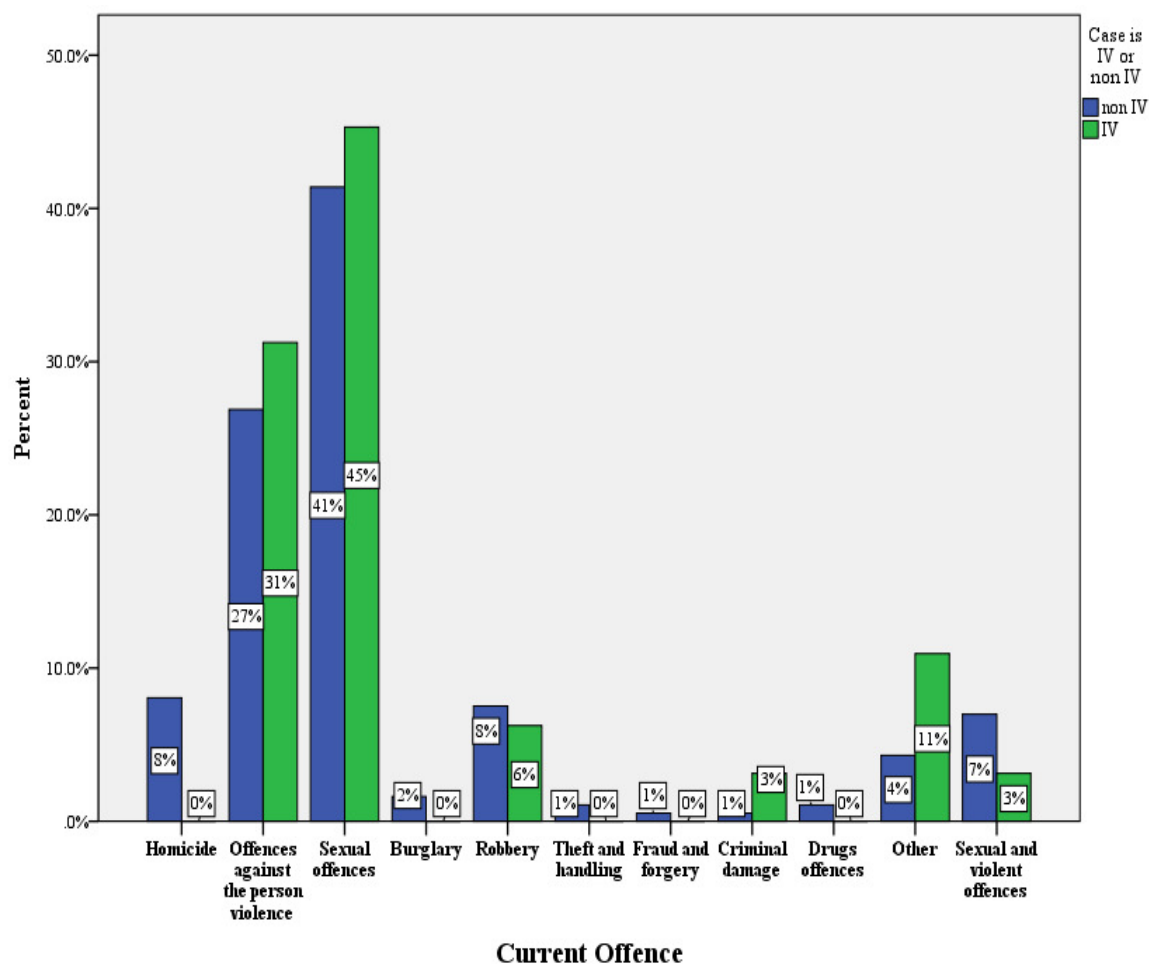
Although the age range of the samples was similar from 15 to 70 non IV and 15 to 69 IV, the mean age was different. An independent-samples t-test was conducted to compare the ages for IV and non IV. There was a significant difference in ages for non IV ( $M = 38.79$ ,  $SD = 12.38$ ) and IV ( $M = 33.59$ ,  $SD = 11.90$ ;  $t(248) = 2.93$ ,  $p = .004$ , two-tailed). The magnitude of the differences in the means (mean difference = 5.2, 95% *CI*: 1.70 to 8.70) was small (eta squared = .03).

**Figure 4.3 Bar Graph Illustrating the Sample Gender Split**

The above bar chart illustrates the proportion of male and female participants in the IV and non-IV groups. This is indicative of an offending population in that the proportion of males to females is much higher.

**Figure 4.4 Pie Charts illustrating the Ethnicity of the IV and Non-IV Sample**

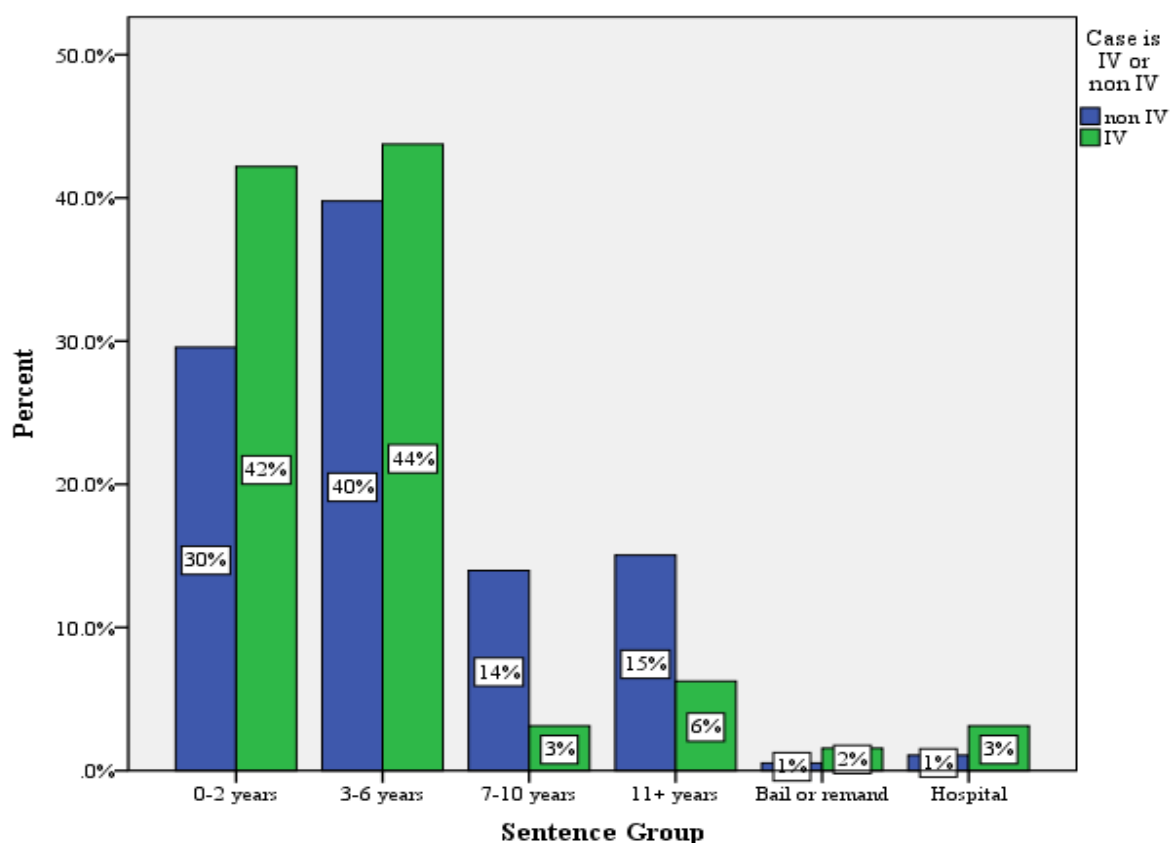
The pie-charts illustrate that the proportion of white participants was greatest in both the IV and non-IV samples. Black and mixed race participants made up the next largest category. There were slightly more Asian participants in the non-IV sample.

**Figure 4.5 Bar Graph Illustrating the Offence Breakdown for IV and non-IV Sample**

In relation to the breakdown of offences committed by each sample there were broad similarities in that the largest proportion was sexual and violent offences. The non IV sample appears to have been convicted of the most serious violence with 8% of offences being homicide compared to 0% of IV cases. However the IV sample had proportionally committed slightly more sexual offences, more offences against the person and criminal damage.

In order to explore any potential relationships between the offence types and the IV and non-IV groups a chi-square analysis was undertaken. The initial analysis showed that 14 cells had expected count below 5. Therefore the data was re-coded as follows; Homicide, Offences against the person violence and Robbery were re-coded to Violent Offence. Sexual Offences remained as Sexual Offences. Burglary, Theft and Handling, Fraud and Forgery, Criminal Damage, Drugs and Other were re-coded to Acquisitive and other offences. The 15 cases that were categorised as Sexual and Violent Offences were omitted from the analysis as they could not be assigned to the new categories (there were 13 non-IV and 2 IV cases in this category).

A Chi-square test for independence indicated no significant association between IV/NonIV and offence type,  $\chi^2$  (2, n = 235),  $p = .481$ ,  $\phi = .079$ .

**Figure 4.6 Bar Chart representing the sentence group of the IV and non-IV groups**

The non-IV group tended to have been given longer sentences (7 or more years) than the IV group. The IV group were more likely to have received shorter sentences (6 years or less) and were more likely to be in secure hospital.

In order to explore any potential relationships between the sentence group and the IV and non-IV groups a chi-square analysis was undertaken. The initial analysis showed that 4 cells had expected count below 5 therefore the data was re-coded as follows; 0-2 years remained the same, 3-6 years

remained the same and 7-10 years and 11+ years were re-coded as 7+ years. The two remaining categories were omitted as even when merged they would still have had a cell count of less than 5, in addition to which they had equal numbers of participants in the IV and non-IV groups as follows; the bail or remand category was omitted; this category had 1 participant in the IV group and 1 participant in the non-IV group. The Hospital group was also omitted; this category had 2 participants each of the IV and non-IV groups.

A Chi-square test for independence indicated a significant association between IV/NonIV and sentence group,  $\chi^2$  (2, n = 244),  $p = .006$ ,  $\phi = .205$ ; those who were IV tended to have shorter sentences.

## Method

A range of statistical tests were used to analyse the data in Study 1. Chi-square tests for goodness of fit were used to compare the proportion of the sample that met IV criteria with the proportions outlined for ID in a number of previous studies.

Chi-square tests for independence were used to explore the relationships between the following categorical variables ID or IV/Non-ID or Non-IV with external controls including licence conditions; police led orders and CJA requirements. Chi-square testing was selected as the most appropriate statistical test to apply to the data as the Chi-square test is suitable for categorical variables that produce nominal data. Chi-square tests for associations between variables by



calculating the significance of difference between expected frequencies and observed frequencies. The data must be in the form of frequencies that can only occur in one cell. Therefore Chi-square was suitable for investigating the external conditions hypothesis.

Expected frequencies are frequencies that are expected to appear in the table if no association exists between the variables, therefore suggesting the null hypothesis is true. Observed frequencies are the frequencies obtained in a research study using categorical variables. In order to avoid type 1 errors (i.e. rejecting the null hypothesis when it is true) an adequate sample size is important. Coolican (2009) advises that sample sizes above 20 make the risk of this type of error acceptably low as Cochran (1954) had suggested that no more than 20% of expected frequency cells should fall below 5. The sample size of 250 in this study was chosen to counteract such potential problems and was well above the minimum sample sizes required.

Coolican (2009) suggests two further ways to avoid low expected frequencies; avoiding low samples for one category. As there are 186 Non-ID and 64 ID cases this should ensure expected frequency cells do not fall below 5. Secondly he suggests using a significance level of 1%. The significance level adopted in this research was in line with the conservative view expressed by Coolican (2009). Prior to commencing analysis frequencies and distribution of data were examined.

### Effect Size

Coolican (2009) notes that the effect size for a 2 x 2 chi square analysis can be estimated using the phi coefficient (also known as Cramer's phi). Cohen (1988) produced definitions for effect sizes

equating to those which could be deemed 'small' (.10), 'medium' (.30) and 'large' (.50), these definitions have been used throughout where appropriate.

Binary logistic regression was used to analyse the key factors data. This is covered in more detail in Chapter 5. The method for Study 2 is covered in more detail in Chapter 6.

### **Summary of Chapter**

The overall rationale for the study has been outlined. The chapter has covered a full description of the participants and the sampling procedure used. The consultation process and ethical approvals have been outlined together with a description of the pilot study process. An overview of the statistical tests utilised in Study 1 has been offered. The next chapters five and six describe the methodology for studies one and two in more detail.

## **Chapter 5 – Study One: Prevalence, Differential Treatment and Key IV Factors**

### **Introduction**

Smith (2008) refers to administrative records such as those held by prisons, probation and hospitals as having the potential to provide ‘very powerful data.’ An example of administrative records is case notes. There is a long tradition of using systematic case note review as a methodology within both health and social sciences research, for example the Health Care Quality Improvement Partnership (HCQIP) has employed retrospective case note review in a number of its clinical audits e.g. National Audit of Psychological Therapies for Anxiety and Depression (2011), HCQIP & Royal College of Psychiatry.

As referred to in chapter 1, when investigating the demographic profile or examining risk factors, O’Brien et al (2010) and Fitzgerald et al (2011) have employed case note review as a technique. Similarly Unwin and Deb (2008) used a case note review methodology in their study of the use of medication for management of behavioural problems in adults with learning disabilities.

Case note reviews have also been undertaken in other areas of intellectual disabilities research such as the study by Lindsay, Holland, Taylor, Michie, Bambrick, O’Brien, Carson, Steptoe, Middleton, Price and Wheeler (2009). Lindsay et al (2009) examined the diagnostic information and adversity in childhood for offenders with learning disabilities who had been referred to and accepted into forensic services. The case notes of 323 individuals were examined. Of the sample 126 had been referred but not accepted into forensic services; the remaining 197 had been accepted.

Clearly case notes and indeed MAPPA files are a rich source of data. A further advantage is the quantity of data that can be collected in a relatively short space of time that would not be available if each offender had to be interviewed. Other benefits of case note review as a methodology include the fact that a wider range of variables can be considered in the time allowed as the data has already been collected.

One of the disadvantages of case note review is that the quality of the data is dependent on the contributors to the case notes or file. In this research the MAPPA files and MAPPA minutes have been compiled by different administrators under the supervision of different MAPPA Chairs. Therefore there will be differences in the level of detail and what is included. Due to their differing experience and training MAPPA Chairs may pay more or less attention to different factors. Similarly MAPPA meeting minutes contents will be influenced by the attendees at the meeting, for example probation, police, social services etc. However the research is collecting data from thirteen different MAPPA Boards across a large geographical region which should balance out these effects. Similarly the MAPPA files were being examined which contain corroborating reports and information from a range of practitioners again controlling for the differences in style and detail.

## **Method**

In order to review the case notes, in this case MAPPA files, as systematically as possible, a Case Review Framework (CRF) was developed to examine pertinent variables, (see Appendix F). The first key construct is the variable Intellectual Disability/Vulnerability which has been described in detail in Chapter 4.

The case review framework (CRF) also captured relevant demographic information such as age, gender and ethnic minority. It was decided that the research would utilise existing established coding systems where possible. In the Probation Service a computerised case management system called ICMS (Integrated Case Management System)<sup>13</sup> is used to record details on individual cases. ICMS has existing coding systems for certain items which have been used such as ethnicity and are indicated on the CRF. These variables were further collapsed into broader categories to enable appropriate testing, this is described below.

The case review framework was applied to the initial (first set) of MAPPA minutes and the most recent set of MAPPA minutes in each case. This is because of the variance in the number of MAPPA minutes there may be for different cases. For an offender who has just been referred to level 3 or level 2 MAPP there may be only one set of minutes from the initial meeting whereas an offender who has been managed by the process for a long time there could be as many as forty sets of minutes. Sometimes the information shared may become repetitive. Therefore the initial minutes and most recent set of minutes to the date on which data were gathered should be representative of the case management and enable more effective data collection. This method also allowed for the introduction of the new MAPPA document set that was launched earlier in 2009 to be used by all areas in the region allowing for greater consistency. Any relevant mental health reports, pre-sentence reports and offending behaviour programme reports from the MAPPA file were also consulted to gather information.

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<sup>13</sup> In late 2013 ICMS was replaced by a different case recording system NDelius, which has been adopted nationally by the Probation Service.

The quantitative data for analysis which were gathered from the MAPPA minutes, was re-coded into categorical variables where relevant and recorded into an SPSS data file i.e. age, offence type, suicide risk etc, that matched the CRF.

## **Description of the Variables**

A full list of variables with original coding information is in the attached Case Review Format coding book, see Appendix F. The following is a list of the key variables included in the CRF with a brief description;

### **Demographic Variables**

Gender – Female, Male, Transgender

Ethnicity – Asian, Black, Mixed race, White, Other, Refusal

Age in years at the point of data collection

### **MAPPA**

MAPPA Level 2 or 3

MAPPA Category 1, 2 or 3

Time Managed at Level 3 (in months from initial registration date to point of data collection)

Time Managed at Level 2 (in months from initial registration date to point of data collection)

## **Offending Behaviour & Risk**

Current Offence – The ICMS categories were changed from the numerous specific offence codes to broader categories to enable more meaningful analysis. The re-defined categories were based on the ‘Principal Offence Categories’ used by the Crown Prosecution Service (CPS) and the British Crime Survey definitions. This research used the following offence categories: Homicide, Violence, Sexual, Burglary, Robbery, Theft and Handling, Fraud & Forgery, Criminal Damage, Drugs Offences, Other and Sexual & Violence.

Sentence Type – Custodial, Community, Life or IPP (Indeterminate sentence for Public Protection), YOI (Youth Offender Institution), Hospital Order, Remand or Bail.

Sentence Length – in years then recoded into groups

Criminal Justice Act - Requirements (where available, see Appendix G)

Criminal Justice Act - Exclusions (where available)

Criminal Justice Act - Prohibited Activities (where available)

Risk of Harm

OASys (Offender Assessment System) Risk of Harm to Children

OASys Risk of Harm to Public

OASys Risk of Harm to Known Adults

OASys Risk of Harm to Staff

## **Interventions**

Community Based Offending Behaviour Programmes

Prison Based Offending Behaviour Programmes

Police Restrictive Orders

Sex Offender Registration Period

Number of additional licence conditions – there are a standard six licence conditions broadly for all people being released from a custodial sentence of 12 months or more, please see Appendix H for more detail on specific conditions. Additional conditions may be added that are tailored to the individual offender. Please see Appendix I for further details. As all offenders that qualify will have the standard six conditions only additional conditions were counted.

Whether an offender has licence conditions, CJA requirements or police led orders will depend on a variety of issues. Firstly in relation to offence type, sentence type and level of risk presented.

**Intellectual Disability/Vulnerability Indicators including –**

*Reference to a Psychiatric Diagnosis of ID*

*Reference to a Psychological Diagnosis of ID*

Reference to Cognitive Impairment

Reference to Head Injury

Reference to Brain Damage

Special School – evidence of attendance at a school requiring a statement of special educational needs

School Failure – evidence of truancy, suspension, exclusion

ID Residential Home – evidence of living in supported accommodation

Wechsler Adult Intelligence Scale (WAIS – Full IQ Test) Score Under 80

*WAIS Score Under 70*



Weschler Adult Scale of Intelligence (WASI – Screening IQ Test) Score Under 80

WASI Score Under 70

*ID Team Engagement – evidence of involvement or pending assessment*

Reference to Autistic Spectrum Disorder/Asperger's Syndrome

ID Other – free text box to record relevant references not covered by the above categories

ID Non ID – case included as ID if they have two or more of the above ID factors

NB One or more of the items in italics were the basis for ID group membership. Two or more of any of the items were the basis for IV group membership.

### **Other key demographic or potential risk factors**

Mental Health – reference to mental health diagnoses e.g. personality disorder

Substance Misuse – broken down into different types of drug use

Alcohol Misuse

Suicide or self-harm

Parenting – any evidence of parental criminality, mental illness or harsh, critical parenting style

Social Skills – any evidence of social skills deficits

Language Difficulties – reference to language delays or communication problems

During the course of the research a review of the CRF was undertaken as some of the variables contained too many categories which often yielded only single participants or no participants. Therefore these were collapsed into more clearly defined and meaningful groups to enable analysis. For example, the ICMS offence codes were collapsed into the eleven broader categories used by the

Crown Prosecution Service (CPS) and British Crime Survey. A revised coding book can be found at Appendix J.

## **Sample**

The sample characteristics and demographic information used for Study One have been described in Chapter 4 above.

## **Results**

This section describes the analyses undertaken and results obtained for each of the three hypotheses related to the prevalence of ID/IV offenders, differential treatment and the key factors related to ID/IV. Each hypothesis will be addressed in turn.

The data generated by the research were categorical – either scale or nominal data, as all of the measures are in categories i.e. MAPPA level or offence type. As categorical data were used the parametric assumptions were not met for most of the data. The only variable with a normal distribution was age.

Therefore the appropriate non-parametric tests were used as described below. These tests are designed to allow examination of associations between variables. As the sample size was 250 issues of a small sample size for specific categories were generally absent.

### **Prevalence Hypothesis - Analysis and Results**

Hypothesis 1 (H1) - The prevalence rate for high risk of harm IV offenders will be in the range of 20-30% in line with the Loucks (2007) criteria used by the Prison Reform Trust.

Initially a frequencies table, see Table 5.1 was generated to examine the proportion of IV and non-IV cases.

**Table 5.1 Frequency of Cases meeting the Intellectual Disabilities Criteria**

<b>Group</b>	<b>Frequency</b>	<b>Percent</b>
IV	64	25.6
non IV	186	74.4
Total	250	100.0

A Chi-square test for goodness of fit was used to compare the proportion of cases with IV with the proportions identified by Mason and Murphy (2002a) as 7%, by Loucks (2007) as 20 -30% and Mottram (2007) as 32%. Cases were categorised as IV or non IV using the criteria for at least two ID indicators from the Case Review Framework (CRF) and then compared against the listed proportions to test for best fit.

A Chi-square goodness-of-fit test indicates there was no significant difference in the proportion of IV offenders identified in the current sample (25.6%) as compared with the value of 25% (taking the midpoint of the 20 – 30% range) that was obtained in a previous nationwide review by Loucks (2007),  $\chi^2 (1, n = 250) = .05, p < .83$ . Therefore the experimental hypothesis was confirmed.

A Chi-square goodness-of-fit indicates there was a significant difference in the proportion of IV offenders identified in the current sample (25.6%) as compared with the value of 7% that was obtained in a previous probation based study by Mason and Murphy (2002a),  $\chi^2 (1, n = 250) = 132.8, p < .00$ . Therefore the proportion of ID cases was significantly greater than that identified in a probation only sample.

A Chi-square goodness-of-fit indicated that there was a significant difference in the proportion of IV offenders identified in the current sample (25.6%) as compared with the value of 32% that was obtained in the study by Mottram (2007),  $\chi^2 (1, n = 250) = 4.71, p < .03$ . Therefore the proportion of cases was significantly less than that identified in the Mottram (2007) study which found 7% had an IQ score under 70 and 25% had an IQ score under 80. Albeit were the proportion of ID offenders identified in the current sample to be compared with the group that Mottram (2007) identified with an IQ score of under 80 this would yield the same result as the test for goodness-of-fit as Loucks (2007).

## **Differential Treatment Hypothesis - Analysis and Results**

Experimental Hypothesis 2 (H2) - Offenders identified as having IV (defined as having two or more of the indicators listed in the CRF) will have significantly higher levels of external controls than the non-IV group.

The data were tested using chi square tests for independence. The independent variable IV or non-IV was tested against dependent variables as follows;

IV/non IV – police led orders

IV/non IV – number of additional licence conditions

IV/non IV – CJA requirements

The data were also tested using chi square tests for independence where the independent variable ID or non-ID was tested against the same dependent variables as above.

### Police Lead Orders

Police Lead Orders include orders such as Sex Offence Prevention Order (SOPO), Anti-Social Behaviour Orders (ASBO's) and Violent Offender Order's (VOO's). This external control is put in place to try and prevent offending behaviour by making any identified risk behaviour an offence by way of a breach of the order. Prior to the analysis the offence profile for each group was examined for any significant differences that could explain for instance why there may be more SOPO's evident in the IV rather than the non-IV group. However as the offence breakdown was similar for

both groups a Chi-square test for independence was applied to the data. A Chi-square test for independence (with Yates Continuity Correction<sup>14</sup>) indicated no significant association between IV/NonIV and whether a police lead order was in place,  $\chi^2(1, n = 250) = 1.41, p = .23, \phi = .085$ .

A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between ID/NonID and whether a police lead order was in place,  $\chi^2(1, n = 250) = 8.9, p = .003, \phi = .204$ . The ID cases were significantly more likely to have a police lead order in place. Therefore for the more intellectually disabled group this particular type of external control was more likely to be in place.

### Licence Conditions

As described in the interventions section above, additional licence conditions (see Appendix I) form a further external control. Some of the cases in the data set were not eligible for licence conditions as they were on a community order, still in custody or in a high security hospital. Therefore prior to analysis the cases were sorted to exclude these, leaving 201 cases for analysis. As the number of additional licence conditions for the remaining cases varied from 1 to 25 it was not appropriate to analyse the data as recorded, given that it was in ordinal rather than categorical form. Therefore in order to enable a useful analysis, a process of visual binning was performed to collapse the large

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<sup>14</sup> The Yates Continuity Correction first proposed by Yates (1934) is a statistical correction made to Chi-square values obtained from 2 by 2 tables such as the Pearson Chi-square used in this research. The correction is used because contingency table analyses are based on dichotomous data, and the statistical Chi-square distribution is continuous, therefore an adjustment must be applied to contingency table analyses, so as to obtain more accurate results. The correction consists of subtracting .5 from each absolute difference between the observed and expected cell frequencies.

number of categories into two groups. The median split<sup>15</sup> identified two categories after this procedure which were 5 or less and 6 or more additional licence conditions. These respective categories were renamed low number of additional licence conditions and high number of additional licence conditions. A Chi-square test for independence (with Yates Continuity Correction) indicated no significant association between IV/NonIV and a high/low number of additional licence conditions,  $\chi^2(1, n = 201) = .726, p = .39, \phi = .072$ .

A Chi-square test for independence (with Yates Continuity Correction) indicated no significant association between ID/NonID and a high/low number of additional licence conditions,  $\chi^2(1, n = 201) = 2.5, p = .113, \phi = .132$ . Therefore neither the IV or ID group were more likely to have additional licence conditions.

### Criminal Justice Act Requirements

As described in the description of variables, interventions section, above there are 12 CJA requirements that are additional external controls and provide the means to prohibit or mandate certain activities and behaviours see Appendix G for more detail. As with the licence conditions some cases in the data set were not eligible for CJA requirements at all as they were on licence, still in custody or in high security hospital. Therefore prior to analysis the cases were sorted to exclude the irrelevant, leaving only 38 Community Order sentenced cases that could have CJA requirements. The number of additional requirements ranged from 0 to 6. Visual binning was performed to collapse this continuous variable into two groups. The groups were 1 or less and 2 or more CJA

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<sup>15</sup> A median split is used to divide a sample into two groups, using the median as the cut-off point.

requirements. A Chi-square test for independence (with Yates Continuity Correction) indicated no significant association between IV/NonIV and a high/low number of additional CJA requirements,  $\chi^2(1, n = 38) = .00, p = .99, \phi = -.06$ .

A Chi-square test for independence (with Yates Continuity Correction) indicated no significant association between ID/NonID and a high/low number of additional CJA requirements,  $\chi^2(1, n = 38) = .00, p = 1.0, \phi = .06$ . Therefore neither the ID or IV groups were any more likely to have additional CJA requirements than the non ID/IV group.

There are no significant differences between the IV and non-IV groups in terms of the additional licence conditions and CJA requirements external controls and the hypothesis is not supported. However the ID group do have significantly higher levels of police lead orders than the non-ID group and therefore the hypothesis is supported to some degree for the most disabled group.

## **ID Key Factors - Analysis and Results**

Experimental Hypothesis 3 (H3) - The ID/IV group of offenders will have higher levels of key factors such as school disruption, mental health concerns, substance misuse than the non-ID/IV group.

Those categorical variables relating to key factors associated with offenders with ID/IV were then tested for predictive ability using binary logistic regression. Peng, Lee and Ingersoll (2002) state that



‘logistic regression is a useful test when variables are categorical.’ It is a powerful tool to use when the outcome measure is dichotomous i.e. ID or non-ID. Peng et al (2002) also state that ‘logistic regression provides knowledge of the relationships and strengths among variables.’ Therefore binary logistic regression was used to assess the impact of this set of predictors on the dependent categorical variable ID/Non-ID and IV/Non-IV. In order to use binary logistic regression variables do not have to be normally distributed. Hence it is a suitable test for this data set where the variables are categorical and not normally distributed i.e. non-parametric.

Agresti (2002) stated that logistic regression is a test to predict group membership. Similarly Pallant (2010) describes logistic regression as allowing the testing of models to predict categorical outcomes with two or more categories. Pallant (2010) also describes how categorical and continuous variables can be included in this one model. In this research one of the key aims was to establish which variables are associated with membership of the ID/IV group.

As discussed in the introduction chapter a number of researchers such as O’Brien et al (2010) and Fitzgerald et al (2011) have sought to identify demographic or risk factors for offenders with ID. Therefore the demographic and risk characteristics identified in previous research such as mental health, abuse and neglect experiences, suicide and self-injury and substance misuse were tested using binary logistic regression to test which of the variables are most predictive of membership of the group ID/IV or non-ID/IV within a high risk community sample.

One of the issues with binary logistic regression is the difficulty in establishing whether multi collinearity exists between the independent variables i.e. the independent variables are highly

correlated with one another rather than with the dependant variable. Another issue is sample size. A small sample with a large number of predictors can cause problems with the analysis. Bergtold, Yeager and Featherstone (2011) found that the mean estimated bias becomes significantly less with sample sizes of over 250, whereas mean estimated bias in coefficient estimates can be as high as 300% in small samples of 100 or less. Therefore the sample of 250 used in this study should help to reduce estimated bias.

In addition to increasing sample size another way to moderate the effect of co linearity is to reduce the number of correlated variables or predictors entered into the model, (Midi, Sarker and Rana 2010). Therefore to try to moderate these issues by entering a lower number of variables into each analysis, each key factor associated with ID/IV group membership was entered into a separately themed binary logistic regression analyses as follows;

Mental Health factors– included variables Psychopathy, Personality Disorder, Mental Illness (this was re-coded from the Axis one variable which had been none, one or two or more diagnoses into 0 = no diagnosis and 1 = one or more diagnoses), Suicide/Intentional Self-Injury.

Childhood Abuse, Neglect and Developmental factors – included variables Evidence of Language Deficits, Evidence of being in the care system, Evidence of childhood abuse, Evidence of social skills deficits, Evidence of parental criminality, substance misuse or violence.

Substance Misuse factors– included the variables Substance Misuse and Alcohol Misuse.

### Mental Health

A binary logistic regression was performed to assess the impact of a number of factors related to mental health on the likelihood of membership of the ID group. The model contained four independent variables (Psychopathy, Personality Disorder, Mental Illness, Suicide/ISI). The full model containing all predictors was statistically significant  $\chi^2(4, N = 250) = 7.79, p < .05$ , indicating that the model was able to distinguish between ID and non ID cases. The model as a whole explained between 3% (Cox and Snell R square) and 5% (Nagelkerke R squared) of the variance in ID status and correctly classified 75% of cases. As shown in Table 5.2 below, only one of the independent variables made a unique contribution that approached a statistically significant level of 0.05 (contribution .058) to the model (suicide/ISI). Table 5.3 shows the frequencies for each of the mental health variables.

**Table 5.2 Logistic Regression on Mental Health Variables**

	B	S.E.	Wald	df	p	Odds Ratio	95% C.I. for Odds Ratio	
							Lower	Upper
Psychopathy	.981	.634	2.397	1	.122	2.668	.770	9.238
PD	-.464	.392	1.405	1	.236	.629	.292	1.354
Mentalill	.345	.321	1.158	1	.282	1.412	.753	2.648
Suicideselfharm	.604	.319	3.589	1	.058	1.830	.979	3.419
Constant	-1.426	.227	39.308	1	.000	.240		

**Table 5.3 Frequencies of each Mental Health Variable**

Variable	ID (64)		Non-ID (186)	
	Yes	No	Yes	No
Psychopathy	5	59	7	179
Personality Disorder	13	51	40	146
Mental Illness	26	38	59	127
Suicide/self harm	34	30	72	114

#### Childhood Abuse, Neglect and Developmental factors

A binary logistic regression was performed to assess the impact of a number of factors related to childhood abuse, neglect and development on the likelihood of membership of the ID group. The model contained five independent variables (Evidence of Language Deficits, Evidence of being in the care system, Evidence of childhood abuse, Evidence of social skills deficits, and Evidence of parental criminality, substance misuse or violence). The full model containing all predictors was statistically significant  $\chi^2 (5, N = 250) = 26.99, p < .001$ , indicating that the model was able to distinguish between ID and non ID cases. The model as a whole explained between 10.2% (Cox and Snell R square) and 15.1% (Nagelkerke R squared) of the variance in ID status and correctly classified 76.4% of cases. As shown in Table 5.4 below, only two of the independent variables made a unique statistically significant contribution to the model. These were evidence of being in care and evidence of language deficits. The strongest predictor of being in the ID group was having language deficits, recording an odds ratio of 5.4. This indicated that those in the ID group were over 5 times

more likely to have language deficits, controlling for all other factors in the model. The second strongest predictor of being in the ID group was having been in the care system, recording an odds ratio of 2.25. This indicated that those in the ID group were over 2 times as likely to have been in the care system as the non-ID group, controlling for other factors in the model. Table 5.5 outlines the frequencies of each of the childhood abuse, neglect and developmental factor variables.

**Table 5.4 Logistic Regression on Childhood Abuse, Neglect and Developmental Factors**

	B	S.E.	Wald	df	p	Exp(B)	95% C.I. for Odds Ratio	
							Lower	Upper
Parents	.722	.396	3.312	1	.069	2.058	.946	4.476
Carehome	.813	.397	4.195	1	.041	2.254	1.036	4.904
Abuse	-.452	.405	1.242	1	.265	.636	.287	1.409
Socialskills	.563	.350	2.582	1	.108	1.756	.884	3.490
Language	1.694	.574	8.712	1	.003	5.439	1.766	16.745
Constant	-1.672	.231	52.216	1	.000	.188		

**Table 5.5 Frequencies of Each Childhood Abuse, Neglect and Developmental Factor Variables**

Variable	ID (64)		Non-ID (186)	
	Yes	No	Yes	No
Parents	33	31	59	127
Care System	19	45	27	159
Abuse History	28	36	64	122
Social Skills deficits	26	38	37	149
Language Problems	11	53	6	180

As language problems could have reasonably been predicted to be associated with ID the analysis was run again removing the language deficits variable. The removal of language deficits from the analysis resulted in some modification of the results. The effect of social skills became more pronounced and reached statistical significance at the 0.011 level. The effect of the item concerned with being in a care reduced to below the 0.05 level of significance as follows;

A binary logistic regression was performed to assess the impact of a number of factors related to childhood abuse, neglect and development on the likelihood of membership of the ID group. The model contained four independent variables (Evidence of parental criminality, substance misuse or violence Evidence of being in the care system, Evidence of childhood abuse and Evidence of social skills deficits). The full model containing all predictors was statistically significant  $\chi^2(4, N = 250) = 17.9, p < .001$ , indicating that the model was able to distinguish between ID and non ID cases. The model as a whole explained between 7% (Cox and Snell R square) and 10.2% (Nagelkerke R squared) of the variance in ID status and correctly classified 74.4% of cases. As shown in Table 5.6 below, only one of the independent variables made a unique statistically significant contribution to the model. This was evidence of social skills deficits. The strongest predictor of being in the ID group was having social skills deficits, recording an odds ratio of 2.03. This indicated that those in the ID group were over twice as likely to have social skills deficits, controlling for all other factors in the model. The second strongest predictor of being in the ID group was having been in the care system although this did not reach statistical significance. Table 5.7 outlines the frequencies of each of the childhood abuse, neglect and developmental factor variables.

**Table 5.6 Logistic Regression on Childhood Abuse, Neglect and Other Developmental Factors Excluding Language Problems**

	B	S.E.	Wald	df	p	Exp(B)	95% C.I. for Odds Ratio	
							Lower	Upper
Parents	.636	.387	2.696	1	.101	1.889	.884	4.037
Carehome	.707	.387	3.339	1	.068	2.027	.950	4.327
Abuse	-.336	.395	.724	1	.395	.714	.329	1.550
Socialskills	.837	.329	6.474	1	.011	2.311	1.212	4.404
Constant	-1.672	.231	52.216	1	.000	.188		

**Table 5.7 Frequencies of Each Childhood Abuse, Neglect and Developmental Factor Variables Excluding Language Problems**

Variable	ID (64)		Non-ID (186)	
	Yes	No	Yes	No
Parents	33	31	59	127
Care System	19	45	27	159
Abuse History	28	36	64	122
Social Skills deficits	26	38	37	149

### Substance Misuse

A binary logistic regression was performed to assess the impact of a number of factors related to substance misuse on the likelihood of membership of the ID group. The model contained two independent variables (Substance Misuse and Alcohol Misuse). The full model containing all predictors was not statistically significant  $\chi^2 (2, N = 250) = 4.02, p > .05$ , indicating that the model

was unable to distinguish between ID and non ID cases. The model as a whole explained between 1.6% (Cox and Snell R square) and 2.3% (Nagelkerke R squared) of the variance in ID status and correctly classified 74% of cases. As shown in Table 5.8 below, neither of the independent variables made a unique statistically significant contribution to the model. Table 5.9 includes the frequencies of each of the substance misuse factors.

**Table 5.8 Logistic Regression on Substance Misuse Factors**

	B	S.E.	Wald	df	p	Odds Ratio	95% C.I. for Odds Ratio	
							Lower	Upper
SubstanceM	.477	.315	2.289	1	.130	1.611	.869	2.989
AlcoholM	.204	.315	.418	1	.518	1.226	.661	2.273
Constant	-1.415	.241	34.452	1	.000	.243		

**Table 5.9 Frequencies of Substance Misuse Variables**

Variable	ID (64)		Non-ID (186)	
	Yes	No	Yes	No
Substance Misuse	37	27	82	104
Alcohol Misuse	36	28	87	99



## **Discussion**

The following section will discuss the findings from each hypothesis in turn and consider the outcomes in relation to other research in addition to the implications for the client group.

### **Prevalence Hypothesis**

The prevalence hypothesis was confirmed and there was no significant difference between the research prevalence rate of 25.6% and the prevalence rate identified in the Loucks (2007) 20-30%. This was also true of the prevalence rate identified by Mottram (2007) for offenders with an IQ under 80. This indicates that the high risk community sample were similar to the groups identified in previous research as those most likely to be disadvantaged by the Criminal Justice System. Whilst this group may not meet the diagnostic criteria for intellectual disabilities they are likely to struggle to fit in with the prison regime or be able to meet the requirements of their licence or community order.

In order to establish a more reliable prevalence rate this research could have adopted a more stringent identification methodology such as that employed by Hayes (2007a). Hayes (2007a) utilised a diagnostic methodology by assessing prisoners at HMP Liverpool using the WAIS III and Vineland Adaptive Behaviour Scales Interview (VABS). Whilst this may have been a more precise methodology it would have been difficult to obtain ethical approval and would have drastically reduced the sample size. The issues surrounding the use of the particular ID variables will be covered in more detail Chapter 7 as if a more stringent criterion had been used this may well have impacted on the results. For example when only those cases who had a psychiatric reference or psychological reference to ID, contact with the LD team or an IQ score under 70 as the ID inclusion

criteria the prevalence rate of 6.8% would have more closely matched the Mason & Murphy (2002a) prevalence rate of 7%.

The implications of the prevalence rate identified for this study is the need to take ID offenders presentation into account. MAPPA panels need to understand that people with ID may need additional assistance with materials such as 'easy read.' In line with other research, Bradley Report (2009) and Talbot (2007) it is important that offenders are routinely screened for intellectual disability. Clearly this has resource implications, but early identification could end up saving money if people are properly treated and therefore use services properly rather than needing to use litigation, as in the case of Gill, to get their needs met.

There was also a paucity of psychological, psychiatric and diagnostic information in MAPPA files. The most frequent predictors of ID group membership were evidence of disrupted schooling; ID noted in diversity considerations, ID other and a file indication of cognitive impairment. Therefore even when ID is mentioned in someone's MAPPA file the level of information about it is negligible on occasion. This may be due to the poor identification. Many reports such as Bradley (2009), Talbot (2007), Loucks (2007) have criticised the Criminal Justice System for failing to systematically identify offenders with ID. The issue of noting ID properly in the diversity considerations section of the MAPPA minutes is also discussed in chapter six as this arose as a sub-theme. It may also be due to staff not understanding the topic and therefore not feeling confident to record it in detail. Or alternatively it may be the case that organisations do not want to identify people who may overwhelm their resources.

### **Differential Treatment Hypothesis**

There was no significant difference between the IV and non-IV groups on any of the external controls, licence conditions, police lead orders and Criminal Justice Act requirements and therefore Brier's (1989) differential treatment hypothesis is not supported. It was anticipated that MAPPA panels would rely more on external controls for the ID group as they may expect that ID offenders would not have the capacity to manage themselves based on internal controls. However the first fundamental issue is that ID offenders are not being reliably identified in the first place. Therefore they are being managed in much the same way as non-ID offenders managed by MAPPA. The data were re-examined using the more strictly defined ID and Non-ID groups and the ID was significantly more likely to have one of the external controls in place, namely police lead orders, which offers some support for the differential treatment hypothesis.

A key concern and implication here is that if this ID offender group are similar to the groups identified by other studies Loucks (2007), Mottram (2007), Hayes (2007a) then they are already experiencing disadvantage in the CJS. If they have poor communication skills they are unlikely to understand the stringent conditions placed upon them and may breach and as a result get recalled to prison more frequently. Alternatively they may breach the police lead orders they are subject to more, which again could result in a prison sentence. Often these orders are written in very complex, legalistic terms. It may be difficult for some individuals to be able to extrapolate the wording of their prohibitions to a range of different circumstances, particularly for offenders on the autistic spectrum. Similarly the Criminal Justice Act 2003 is in the process of being updated and in some instances replaced by the Criminal Justice and Courts Act 2014; therefore CJA requirements will no

longer exist in their current form. However it will be just as important to ensure that whatever their requirements, ID offenders are aware of their sentence and how to comply with it. Therefore an important area for further research would be to examine the breach rate of ID offenders compared to non ID offenders for licence conditions and police lead orders.

However one area of good practice is the easy read version of the licence conditions that has been produced by the intellectual disability advocacy group, CHANGE (website accessed 15<sup>th</sup> May 2014). CHANGE have converted a number of CJS documents into 'easy read' versions for offenders with ID or literacy difficulties. They have also produced a set of CJS easy read symbols and guidance on how to convert documents into more accessible formats. Practice changes such as this could benefit a high proportion of offenders.

One area where ID offenders have been found to have been disadvantaged is their probability of re-arrest. Cockram (2005) examined the total population of people with ID in Western Australia who had been first arrested since 1 April 1984 then followed them over a period of 11 years. Cockram (2005) found that ID offenders had a significantly higher rate of re-arrest than mainstream offenders. Cockram proposes the idea of 'the momentum of official notice', namely that once a person is in the CJS they are more likely to enter a self-generating process of future involvement, which would also be true for mainstream offenders. But for ID offenders who are generally more suggestible or impulsive this may be even more likely. Similarly a further compounding factor may be that Police hold biased attitudes towards people with ID. McAfee, Cockram and Wolfe (2002) found that police were more likely to find alleged ID offenders less believable and their offending more serious than non-offenders when asked to respond to crime reports which contained the same aspects in relation

to content other than the alleged perpetrator characteristics. The police also indicated they would take more drastic action towards the ID offenders. It is unsurprising that ID offenders get caught in the CJS cycle and find it difficult to get out. As a statutory agency for MAPPA, Police attitudes towards particular groups of offenders are an area that warrants further research and consideration.

It may also be that due to the high risk of harm presented by MAPPA managed offenders that a higher level of external controls could be expected and is in fact appropriate to maintain public protection. Whilst this research found only partial support for one element of differential treatment for the ID group in respect to external controls placed upon offenders managed by MAPPA it is clearly an area that requires further investigation in the wider CJS.

### **Key factors Hypothesis**

In relation to examining the key factors including demographic and potential risk factors relating to ID the most significant results were evidence of being in care and evidence of language deficits. The strongest predictor of being in the ID group was having language deficits, recording an odds ratio of 5.4. This indicated that those in the ID group were over 5 times more likely to have language deficits. As referred to above in the prevalence hypothesis section, communication difficulties are a key consideration when working with offenders with ID. Despite this the provision of speech therapy services are rarely considered as part of programmes of intervention in the CJS, as illustrated in the Gregory and Bryan (2010) study outlined in Chapter One.

Language deficits can be one of the more visible signs of someone having ID or indeed experiencing difficulty in communication and therefore must be taken into account when working with people. Clearly there are implications for their journey through arrest, court, prison and probation, for example do they understand what is happening to them and what the long term consequences may be? There was clear overlap between this finding and one of the main themes identified in study two. A visible difficulty such as a language deficit may well set them up to fail or to be vulnerable in a system that exposes them to other more cognitively able offenders.

The second strongest predictor of being in the ID group was having been in the care system, recording an odds ratio of 2.25. This indicated that those in the ID group were over twice as likely to have been in the care system as the non-ID group, controlling for other factors in the model. This is an interesting finding given that offenders as a group are already over represented in terms of experiencing local authority care. Williams, Papadopolou and Booth (2012) examined prisoners' childhoods and family backgrounds and of the 1,435 prisoners in their study, 24% stated they had been in care at some point in their childhoods. In relation to the ID group is it because they are ID that they are being placed into care more and this heightens the risk of entering the CJS, or is being in the care system itself a high risk factor for any child and subsequent entry to the CJS? Again there are strong links with Study Two and some of the early life experiences that the ID group had. Clearly some of these children were placed into care due to parental factors of abuse or poor coping. What is not clear is the effect of whether a child is placed into care because their parents cannot cope or because their parents are abusive or neglectful and the local authority intervenes. Again the relationship between these abusive and situational factors and ID is complex. What is clear is that being in care as a child or indeed as an adult places the individual at elevated risk of harm. The

Department of Health (2012) published the government recommendations following the abuse that occurred at Winterbourne View, a home for people with learning disabilities and complex needs. The review examined the wider care system and exposed concerns about how people with ID or autism and a mental health diagnosis were being treated. The concerns were listed as follows;

Inappropriate placements – too many people are being placed inappropriately in hospitals for assessment and treatment, and staying there for long periods.

Inappropriate care models – too few people are experiencing personalised care that allows them to be in easy reach of their families, or their local services.

Poor care standards – there are too many examples of poor quality care, and too much reliance on physical restraint.

Many of these concerns could equally apply to the CJS. If court diversion schemes are inadequate then people with ID may be sentenced to prison inappropriately. Whilst there they will be unable to access personalised care or be in easy reach of their families. They are also likely to be subject to physical restraint or even other forms of abuse by staff or assault or exploitation by other prisoners if prison officers do not understand the presentation and how to manage it.

Finally in relation to risk to self, the only one of the independent variables that made a unique contribution that approached a statistically significant level of 0.05 (contribution .058) to the logistic regression model examining mental health issues was suicide/ISI (Intentional Self Injury). Over half the ID group had an elevated risk of suicide and ISI present.

Heslop and Macaulay (2009) examined the issue of intentional self-injury and people with learning disabilities. They interviewed 35 people with ID over a three year period and several family members and key workers. They found that whilst such self-injury tended to be a very 'individual affair' it was most likely to happen in response to difficult circumstances. Several factors were linked to difficult circumstances such as external factors like the person not feeling in control of their life or environment; interpersonal factors such as feeling angry or frustrated at being bullied or being involved in arguments and finally internal factors such as physical health issues or having troubling thoughts about previous abuse or traumatic events. It is likely that many offenders feel out of control of their lives especially when in prison. The ID group in this study had high instances of abuse and experience of the care system and so were likely to have troubling thoughts about previous trauma.

There is very little direct research about suicide and ID. However one Finnish study by Patjal (2001) completed a 35 year follow up of suicide mortality in 'mental retardation.' They followed a cohort of people with ID (MR) who had completed suicide and found that men with MR had much lower rates than the general population whereas women with MR had an equal risk to other Finnish women. They reported that the risk factors for suicide were similar to those in the general population. They also found that most of their sample had mild MR and were in hospital for co-morbid mental disorders.

The issue of risk to self can often be overlooked within MAPPA when there is heightened concern about risk to others. Therefore it is particularly important that the risk to self is considered for the ID group. Heslop and Macaulay (2009) advocate that intentional self-injury in people with learning



disabilities should be addressed as it is with anyone else. Similarly Patjal (2001) found that risk factors for suicide were similar to the general population. Therefore no additional training or resources are required other than awareness that suicide and ISI can be just as relevant to the ID offender population as the general population.

## Summary

This chapter has covered the analysis and results for the three hypotheses for the quantitative research study. The prevalence hypothesis was confirmed with a prevalence rate of 25.6% of cases identified as IV in line with Loucks (2007) criteria of 20-30%. The external controls hypothesis was not supported for the IV group. The ID cases were significantly more likely to have a police lead order in place but there were no differences between the licence conditions and CJA requirements external controls between the ID and Non-ID groups. The key factors hypothesis suggested that those in the IV group were over 5 times more likely to have language deficits and over 2 times more likely to have been in the care system. When controlled for language deficits the IV group were over 2 times more likely to have social skills deficits. There was also an association between the IV group and a risk of suicide and ISI which approached but did not reach statistical significance at the 0.05 level of significance. There are also links with Study Two in respect of suicide and ISI within the mental health theme.

Whilst study one has yielded some interesting and useful results, there are issues that it would be beneficial to investigate further. In study one the focus was on collating statistical data to answer the

hypothesis. Therefore in study two a stronger focus on the key factors surrounding ID/IV will be taken and explored more thoroughly.

## **Chapter 6 – Study Two: ID/IV Offenders the Central Issues?**

### **Introduction**

Study two examined the central issues relating to ID/IV offenders by considering the discourse about them contained in the MAPPA minutes. As referred to in chapter one Hayes (2008) noted the difficulty of establishing a diagnosis of intellectual disability due to paucity of information about an offender's past. Similarly in the context of MAPPA, Wood et al (2006) found that MAPPA minutes rarely articulated the distinction between psychological and psychiatric concerns. Study one focussed on collating statistical information about the ID/IV group, comparing them to the non-ID/IV group, whereas study two focussed on obtaining a deeper level of understanding of the ID/IV group by examining the discussions that were taking place about them in the MAPPA minutes.

Banister (2008) advocates the use of multiple methods within forensic psychology and suggests that 'qualitative and quantitative methods both help to illuminate problems and their solution.' A number of approaches were considered in order to analyse the qualitative data. Interpretative Phenomenological Analysis (IPA) is an approach with an idiographic focus, which means that it aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon (Reid, Flowers & Larkin, 2005). Grounded theory was developed by Glaser and Strauss (1967) with the stated aim 'to generate or discover a theory.' Neither of these approaches met the research aims as what was required was a deeper level of understanding of the ID/IV group and the discourse about them rather than theory development or how ID/IV individuals were making sense of certain phenomenon.

Some of the further qualitative approaches that were considered included content and discourse analysis. Kohlbacher (2005) describes content analysis as a type of quantitative method with a system of categories at its core, which at the simplest level involves counting the number of occurrences of each category. Approaches such as content analysis which tend to focus on word counts would take analysis back to a more quantitative approach, which has been addressed in study one. Similarly whilst some MAPPA minutes recorded the discussions in meetings verbatim which would have yielded data suitable for discourse analysis, some meeting minutes provided more summary information which would not have been suitable for this type of analysis.

Howitt and Cramer (2010) stated that thematic analysis can be a useful method as long as the researcher adopts a systematic approach and follows the key aspects. Ryan and Bernard (2000) argue that thematic analysis is in fact a form of grounded theory. However Braun and Clarke (2006) argue that thematic analysis differs from grounded theory, as grounded theory is related to a philosophical position and thematic analysis is not. Similarly they argue that grounded theory also aims to develop an overarching theory that explains the data findings, whereas the themes from a thematic analysis seek to summarise the data. The focus of study two was to summarise the themes from the MAPPA minutes and then consider the similarities and differences from the study one results.

Therefore thematic analysis was used to identify the discussions taking place within MAPPA minutes regarding ID/IV and to draw the relevant themes from this data. This enabled deeper reflection about this client group. In order to capture the qualitative data from the minutes Braun and Clarke's (2006) six stage method of thematic analysis was used, which is described in further

detail in the methods section below. By using Braun and Clarke's (2006) prescribed method Howitt and Cramer's (2010) criteria for following a systematic approach to improve the quality of the research can be met.

## **Method**

In Braun and Clarke's (2006) article 'using thematic analysis in Psychology', they describe a process of data analysis to apply to the data corpus. Data corpus is the term they use for all the data the process is to be applied to. The data set is what results from it. In this research the data corpus is the detail taken from the body of the MAPPA minutes. Braun & Clarke (2006) then describe a data item as being each piece of individual data collected. In this instance the topic of interest is intellectual disability. As has been outlined in chapter 1 this can interchangeably be referred to as learning disability. The final term the researchers use is data extract. Data extract is used to describe the individually coded chunk of data that has been extracted from a data item.

Braun and Clarke (2006) propose six stages to undertaking thematic analysis. The first stage is 'Familiarisation with the data.' This stage advocates the reading and re-reading of the data, noting down initial ideas. The 'total immersion' in the data starts the process of initial themes, patterns or ideas.

The second stage is ‘generating initial codes’ which involves a systematic coding of all interesting features of the data across the data set. The codes identify elements that may build up to themes. This stage is about data organisation rather than interpretation.

‘Searching for themes’ is the third stage which prompts the researcher to gather the codes of all relevant data into themes. Braun and Clarke (2006) recommend the use of various visual representation techniques such as mind maps or tables to start organising the codes into themes.

‘Reviewing themes’ then splits themes into two levels. Level 1 is checking whether the themes work in relation to the coded extracts. Level 2 is checking whether themes work in relation to the entire data set. A thematic ‘map’ of the analysis should be generated by this stage.

The next stage is ‘defining and naming themes.’ This stage requires ongoing analysis which should refine the specifics of each theme by giving each theme a clear definition and name. This should lead to developing the overall story the analysis tells. The story that each theme tells should be considered in the context of the overall research questions. It is important the names ascribed to the themes are descriptive so as to inform the reader what the sense of the theme is.

The final stage is ‘producing the report.’ Here Braun and Clarke (2006) advise selecting illustrative extracts, relating the analysis back to the research question and literature and producing a ‘scholarly’ report. The illustrative extracts should be just that and support the arguments in relation to the research questions.

### Research Question for Thematic Analysis

What are the discourses around intellectual or learning disability and learning difficulties in the MAPPA minutes?

Other issues to be explored were;

The type of management strategies used with ID/IV offenders.

The number of restrictive or pro-social opportunities afforded to ID/IV offenders managed by MAPPA.

Braun and Clarke (2006) advocate the use of the following questions to aid analysis;

‘What does the theme mean?’

‘What are the assumptions underpinning it?’

‘What are the implications of the theme?’

‘What conditions are likely to have given rise to it?’

‘Why do people talk about this thing in this particular way (as opposed to other ways)?’

‘What is the overall story the different themes reveal about the topic?’

A further recommendation offered is to link the findings with those already identified in the literature. Therefore where relevant, themes will be linked to issues raised in chapter 1.

At each data collection site a separate word document was created. As each MAPPA file was reviewed relevant information from the MAPPA minutes was recorded into a word document. Each participant had a type written entry. These word documents that contained all of the data formed the

‘Data corpus.’ Each of the excerpts from the minutes relating to intellectual disability is a ‘data item.’ All data were recorded using different initials and removing any identifiable locations or services to maintain the anonymity of participants.

The six stages of analysis proposed by Braun and Clarke (2006) were closely followed. Firstly the data were read and re-read until initial themes started to emerge. Initial codes were ascribed to the data items to assist collation into themes. At this stage the data relating to the broad themes were cut and pasted into an Excel spreadsheet. This allowed for clearer organisation of the written material and followed the visual representation guidance offered by Braun and Clarke (2006). The ‘data extracts,’ the individually coded chunks of data that had been extracted from a data item, were then sorted into sub-themes by using new tabs within Excel.

A second researcher who had previous experience of using thematic analysis was used to independently ascribe initial codes and themes. By using a second researcher a higher level of inter subjectivity could be reached as whilst the second researcher was familiar with the method they were not as familiar with the aims of the research study. Similarly in order to increase objectivity the researcher undertook the thematic analysis prior to the study one analysis. Prior to the commencement of the analysis it was important for there to be agreement between the researchers of how to resolve differing views on theme identification. Both would present their arguments for the theme, a check on the other themes for similarities or differences and in the event of no agreement being reached the main researcher would have the final decision. In the event this was not necessary as there was a high degree of agreement between researchers.



The initial codes were then compared for similarities and differences. Howitt and Cramer (2010) suggest that researchers offer information on the ‘incidence and prevalence’ of each theme in the data. Therefore agreement was reached that in respect of prevalence a main theme would require at least two thirds of the sample to contain a relevant data extract and a sub theme would require at least a third of the sample to contain relevant extracts. Each data extract was cut and pasted into an Excel spread sheet to construct a final set of themes. The themes were then transcribed into a thematic map, see figure 6.1 below. From this thematic map it was possible to check that the themes worked in respect of reflecting and explaining the data. A clear definition and description was developed for each theme which is explained in the following results section.

## **Sample**

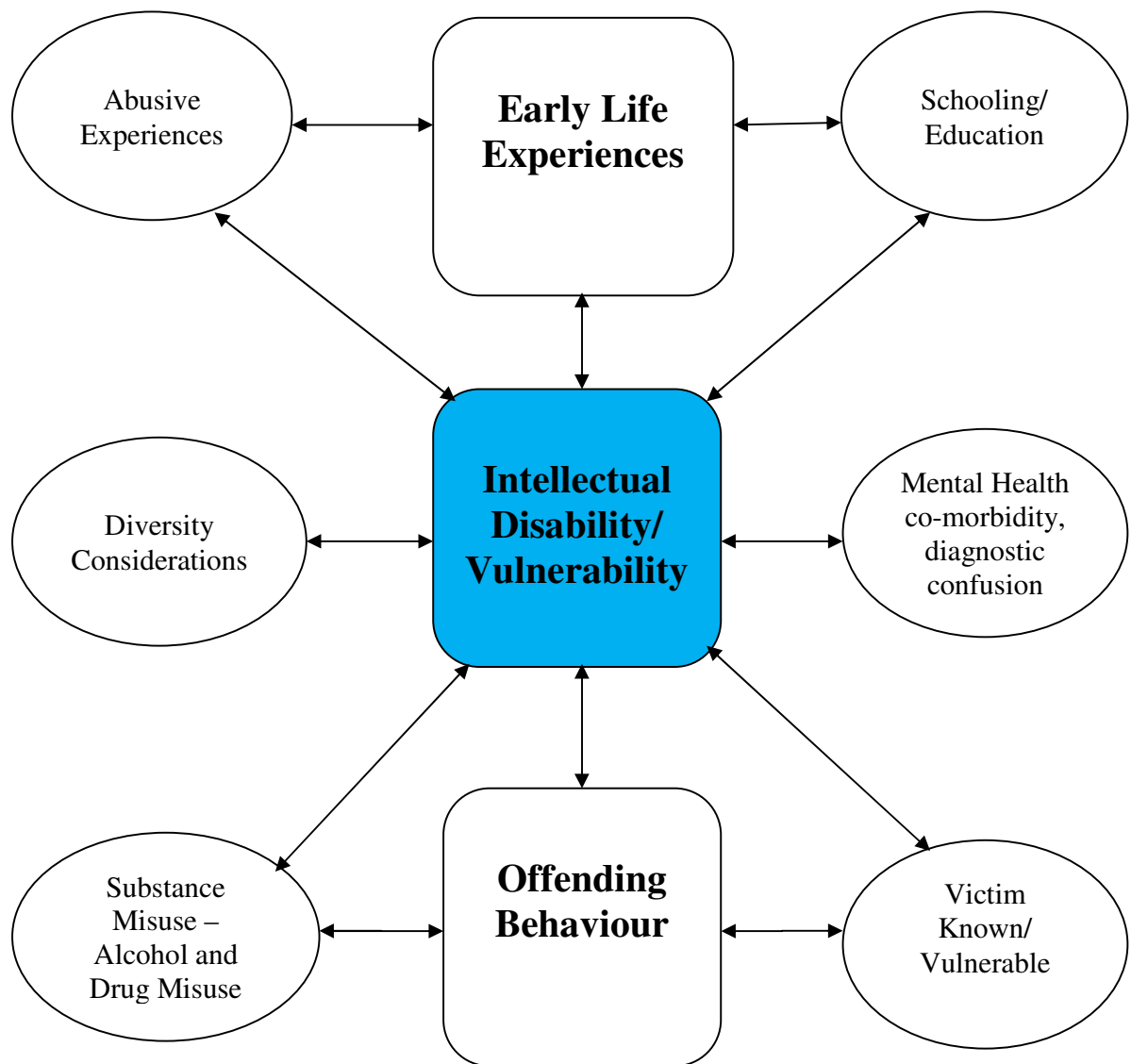
The thematic analysis focussed on the cases that had been identified as IV/ID which was described in more detail in chapter 4. There were 64 participants that met the IV/ID criteria of which 60 were men and 4 were women. They were aged from 15 to 69 with a mean age of 34. All demographic information about this sample can be found in chapter 4.

## **Results and Discussion**

This section addresses the results of the thematic analysis and discusses the outcomes. The research question for the thematic analysis was ‘What are the discourses around intellectual or learning disability and learning difficulties in the MAPPA minutes?’ Throughout this section the main and

sub themes will be identified and related to the relevant literature. Please note that direct data extracts from the MAPPA minutes are recorded in italics, therefore any grammatical errors or distortions are intentional as this data were copied exactly from the MAPPA meeting minutes. Similarly a series of dots such as .... indicate that this element of the data excerpt has been removed as it was more relevant to a different main or sub theme.

A model of the main themes is shown in figure 6.1 below. The main themes are shown in squares with sub themes in ovals.

**Figure 6.1**Thematic Analysis Map

### **Main Theme - Intellectual Disability/Vulnerability**

The main theme of intellectual disability/vulnerability covered a wide range of aspects. Two key sub themes emerged, Mental Health and Diversity Considerations which are covered in the next section. The main discourse around intellectual disability/vulnerability alluded either to existing issues or to the need for assessment. One illustrative data extract stated;

*‘Significant deficits in literacy and numeracy, dyslexic. Offender says he felt admissions were extracted from him by his defence team and the Police without Court processes being properly explained to him. Poor reasoning and high level of cognitive distortions.’*

The sense of people with ID/IV being confused and needing assistance to understand the Criminal Justice System was evident in a number of cases. For example;

*‘ x ‘suffers from Asperger’s Syndrome. Also that he has an IQ of 72 and because it is not 70, Adult services will not get involved. Dr L reported he has limited understanding which is at a much lower level than we originally perceived. She suggested a number of ways in which Police can explain his SOPO<sup>16</sup> conditions to him to help him understand.’*

Whilst there was some evidence of appropriate assistance being offered by knowledgeable professionals as described in this data extract, clearly the previous extract alludes to people who do not understand the process and may unwittingly incriminate themselves. This supports one of

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<sup>16</sup> SOPO - Sex Offences Prevention Order. An order that is made in Civil Court but enforceable in Criminal Court.

Brier's (1989) arguments in relation to differential treatment of ID offenders, namely that they lack the skills to effectively dissemble.

Some good practice was evident with discourse about the type of adapted offending behaviour treatment programmes that were suitable for people with ID/IV;

*'This report was completed by Dr x, Consultant Psychologist. This report concludes that Mr. C has a formal diagnosis of intellectual disability (Learning Disability), with an IQ score of 72 suggesting he falls within the mild intellectual disability range. Dr x stated that he considered it appropriate for Mr. C to attend a Learning Disability adapted sex offenders treatment programme in the community.'* A further extract stated; *'Had an assessment in custody for the Adapted Programme. Has learning difficulties so must ensure these are being met.'*

Clearly if ID/IV is not identified early enough there can be serious implications for offenders unable to meet their sentence planning requirements such as serving over tariff and remaining in custody far longer. In another data extract the person is clearly unable to meet the requirements of the Enhanced Thinking Skills course;

*'In HMP B Has done ETS for 3rd time – Feedback indicates he still doesn't understand anything about his offending behaviour i.e. poor progress.'*

Similarly other discourse alluded to the behaviour of ID/IV clients who were having difficulties with time keeping and as such meeting their sentence requirements. Some of the language used conveyed

a sense of suspicion about the person with ID/IV and how this was impacting on their behaviour, for example;

*'He attempts to manipulate by blaming his learning difficulties. He has been challenged on his behaviour towards professionals; he has chuckled and agreed that he does try to get his own way. When he is challenged robustly he can become verbally aggressive. It was noted that by TS that in custody he appears to cope however, he is vulnerable in the community and we need to be mindful of this. TS reminded everyone that S takes everything that is said to him literally and because of this everything needs to be explained thoroughly. Following a warning letter for failing to disclose a developing relationship, he claimed that due to his learning difficulties he had not understood the condition.'*

It may be argued that some of the language used about offenders with ID/IV was not very skilful or professional and that this contributed to labelling the person rather than attempting to understand their difficulties;

*'Presents as extremely childlike.'*

*'Presenting as very emotionally childlike.'*

*'I have always thought this because he is a bit slow in the head'.*

*'R will ask for assistance although he is and can be economical with the truth.'*

*'He is fully occupied but does have to get a bit more organised.'*

*'Main concern is R's missed appointments with his Keyworker, although he does apologise'. '..with a low tolerance to frustration and a limited ability to learn from his experiences.'*

If staff were more aware of the organisational difficulties that could be attributed to ID/IV or learning difficulties and if this was more clearly understood then appropriate adjustments could have been made to assist, rather than the sense of frustration that someone is being deliberately obstructive. Clearly the issue of offenders with ID/IV and differential treatment has been central to this study and has also been covered in study one. Therefore the issue of people with ID/IV being disadvantaged in the CJS is addressed further in the discussion section, Chapter 7.

### **Sub Theme Mental Health**

The sub theme of mental health was characterised by a high level of diagnostic confusion or multiple diagnoses. Much of the discourse focussed around mental health diagnoses in addition to the intellectual disability/vulnerability. Clearly there is a recognised high level of co-morbidity between intellectual disability and mental illness as illustrated by the Royal College of Psychiatrists (2003) Council Report on meeting the mental health needs of adults with a mild learning disability. There appeared to be a high level of diagnostic confusion and a sense that the person had complex needs. This led to numerous data extracts suggesting a high degree of diagnostic confusion, with several diagnoses being suggested to try and explain an individual's presentation. These diagnoses ranged from psychotic disorder such as schizophrenia to autistic spectrum conditions. The following data extracts were representative of this discourse on diagnostic confusion;

*‘PNC<sup>17</sup> markers for mental health/mental disorder. There have been incidents where offender has disclosed to a teacher and his mother that he has urges to abuse young children and he also hears voices which tell him to hurt people. He appears to suffer from depression. His mother has also reported that he has been sexually explicit towards her. ... he was assessed by the CMHT but has not been picked up. He does not have a mental health problem. He was referred to the psychology department to look at autism. Also to see if there are any organic problems.’*

*‘Receiving psychiatric support from EH. A Dr S assessed him and diagnosed him with schizophrenia and in 2003 confirmed he has epileptic episodes due to being hit on the head with a hammer. Despite this he was told at sentencing by a Forensic CPN that he had no enduring mental health illness. Clarification has been sought from prison in-reach. They confirmed he was undergoing psychiatric intervention but refused to specify details. RS agreed to check his history for psychiatric intervention. ... contributed to the potential early onset of dementia. Offender has been assessed as having a potential personality disorder due to his history of drugs and alcohol consumption.’*

Clearly MAPPA cases represent the highest risk and most complex offenders. As the meetings are attended by staff from a number of different agencies it is all the more important that they understand diagnoses and how these may impact on the person’s presentation. However as covered in chapter one there is often a high degree of overlap between the symptoms for different diagnoses and little difference between some groups. For example Alexander, Green, O’Mahony, Gunaratna, Gangadharan and Hoare (2010) examined the diagnosis of personality disorder in offenders with intellectual disability. Alexander et al (2010) commented that their most striking finding was the

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<sup>17</sup> PNC is the Police National Computer. This database has several different warning markers for staff to be aware of when working with an individual, one marker is for mental ill health or disorder.



degree of similarity in terms of co-morbidity between the personality disordered and non-personality disordered ID/IV groups rather than the differences. Therefore perhaps a more sensible means of sharing information about ID/IV and mental health would be to ensure that a clear formulation is presented describing how a person's particular set of difficulties may impact on their behaviour and presentation and how professionals may adapt their approach to working with the person accordingly.

Also typical were references to several assessments being undertaken but no sense of these being 'joined up', continuous or collated. Often assessments were missed as people moved around the Criminal Justice System and the language used had a sense of frustration that information was missing or funding was not available;

*'It was felt there would be some merit in a joint assessment by Forensic and Autistic Spectrum Disorder Services. Due to a prison transfer this did not take place.'*

*'Discussion around whether a psychological assessment has taken place then about funding and how to get the offender to engage? Also reference to therapeutic needs not yet met.'*

*Mr. X states that he has no current problems with mental health but in the past has suffered from depression. He relates the self-harm to feeling left out of his family. He was referred to CAMHS, which he found useful. 'Mr. X did have a cognitive assessment at HMP A but now he is at HMP B they have a different system and currently there has been no further movement on this matter. ...*

One of the issues that MAPPA face is the sharing of medical information. Despite Royal College of Psychiatry guidance (Taylor & Yakeley, 2013) on the importance of sharing pertinent mental health information it can still be very difficult for MAPPA panels to obtain access to relevant reports that would inform risk assessment and management. Similarly due to the volume of movement around the CJS it is not unusual for relevant information about the offender failing to be transferred to new locations. Hence the difficulties with paucity of file information and assessment information not being shared.

Several data extracts discussing mental health issues referred to head injuries occurring during adult life. The role of 'head butting' both walls and other people is referenced. There were also several instances of severe head injury occurring as a result of assaults from others and in some instances weapons used to inflict injuries included a meat cleaver, hammer and dumb bell. The impact of these injuries is also referenced in terms of amnesia, blackouts, memory loss, epilepsy and the possibility of brain damage. Some of the diagnostic confusion referred to above may be due to a lack of clarity on the involvement of organic causes for injury. The issue of traumatic brain injury and the high prevalence in the offending population has been examined in depth by Williams (2012). Most strikingly Williams (2012) states 'Moreover, it is likely that problems with attention, memory, and executive functions (neuropsychological sequelae) would limit capacity to fully engage in forensic rehabilitation to enable behaviour change, such as the ability to pay attention, remember, and follow through on advice about new ways to manage a problem situation.' Thereby linking with the points made earlier about the level of disadvantage experienced by ID/IV offenders and how expectations of them may not be reasonable or achievable.

As brain damage and head injury were key ID/IV variables this issue is covered in more depth in the final discussion, chapter 7.

Finally the issue of suicide and intentional self-injury (ISI) was present in a number of the mental health data excerpts as follows;

*‘that he had seen a Psychiatrist whilst in HMP F and had attempted to cut his wrists while there’*

*‘These events caused episodes of depression, self harm and suicidal feelings.’*

*‘He has been assessed as acutely suicidal on a number of occasions in the past and has been treated as an in-patient in a psychiatric hospital ward as a result.’*

*‘He says he self-harmed by way of cutting his arms and legs.’*

As discussed in Chapter 5 the issue of suicide and ISI is as relevant to the ID/IV offender population as it is to the non-ID/IV population. Therefore it is essential that MAPPA place as much emphasis on risk to self as it does on risk to others.

### **Sub Theme - Diversity Considerations**

The discourse included in the ‘Diversity Considerations’ section in the MAPPA minutes was of interest. Diversity Considerations are a discrete section of the MAPPA minutes pro-forma and as such should have been the area where any adjustments or considerations about ID/IV were included. Given this is the one section of the MAPPA minutes in which it should be assumed that intellectual

disability would be mentioned, it is perhaps surprising that the data extracts here were variable. Whilst most directly referred to intellectual disability/vulnerability some clearly stated ‘no diversity considerations’ despite alluding to ID/IV in other areas of the minutes or the MAPPA file containing pertinent information. Some of the data excerpts focussed on more specific diagnoses and presentations other than ID/IV.

An example of good practice in recording appropriate diversity considerations in respect of ID/IV is as follows;

*‘X has borderline learning difficulties. The care management assessment will identify this and how this can be managed and what social services funded support will be available on release. The MAPPA is seeking specialist accommodation to meet his needs.’*

Perhaps less helpful were the entries that just stated what the diversity consideration was without any advice on how to make appropriate adjustments such as;

*‘she has mild learning difficulties’ or ‘Suffers from Aspergers Syndrome.’*

Even less helpful was the complete absence of any information or a statement of ‘no diversity considerations’ which featured on a number of cases which had other information pertaining to ID/IV issues in the body of the minutes. This relates back to the ID/IV main theme issue of not recording information about ID/IV constructively or effectively. This section provided an opportunity to record what the diversity consideration was and how to manage it but this was only evident in a few cases. However if ID/IV is not properly identified in the first place it is inevitable

that this section will not be completed properly. The issue of poor identification of ID has been highlighted by the Prison Reform Trust (2008) and the Bradley Report (2009).

### **Main Theme – Early Life Experiences**

A lot of MAPPA minutes alluded to the early life experiences of participants with ID/IV. The data extracts that contributed to the development of this theme referred to complex family situations and challenging behaviour during childhood. The two sub themes that were identified by the analysis were abusive experiences and schooling/educational issues.

The early life experiences of the ID/IV group frequently involved experiences of the care system due to poor parenting as illustrated by the following data extracts;

*‘He and sister taken into care when younger due to neglect, poor care evident at school. Sister remained in care and he was returned home’*

*‘as a result he spent long periods in care of the local authority from the ages of 0 to 9 only to be returned to his mothers care’*

*‘Was removed from the family home but through her non-attendance at school.’*

It is unsurprising that ID/IV cases were removed to local authority care given the situations they were facing at home. In relation to the parents of the ID/IV cases there was frequent reference to

parental substance misuse, mental health diagnoses and relationships being frequently chaotic. Data extracts that illustrate these issues include;

*‘He told me both his parents abused drugs and alcohol.’*

*‘The psychiatric report details that his mother suffered from paranoid schizophrenia.’*

*‘He described his childhood as very bad. He said that his mother and father were both alcoholics. He said that his father would make him go and steal things for him and if he didn’t then he would become physically abusive. Grew up in a Romany gypsy family, pro-criminal.’ ‘Offenders parents have issues with mental health, mother with depression and father with bipolar.’*

Sadly the issue of childhood abuse and neglect is common amongst the general offender population and Farrington (2004) commented upon family factors as being one of the main risk factors for the early onset of offending. Farrington (2004) listed the following as relevant family factors; ‘poor parental supervision, harsh discipline and child physical abuse, inconsistent discipline, a cold parental attitude and child neglect, low involvement of parents with children, parental conflict, broken families, criminal parents and delinquent siblings.’ Certainly many of these issues were present within the ID/IV group of this study; the specific issues of abuse are outlined in the next section.

### **Sub Theme - Abusive Experiences**

There were frequent references to accounts of both sexual and violent abuse perpetrated on the ID/IV participants. Frequently participants had been involved in domestic abuse incidents; both witnessing their parent's conflict and being harmed themselves. Allington-Smith, Ball and Haytor (2002) state that 'children who have a learning disability are at increased risk of sexual and physical abuse and neglect. They and their families are more likely to be socially isolated and to suffer material and emotional poverty.' Some data extracts that illustrate this point are as follows;

*'When growing up witnessed and experienced DV. Father pursued them when mother tried to leave. Contact with Social Services – offender often seen with bruising, referred due to belt buckle mark on his back.'*

*'Abuse from his father caused him to suffer burst eardrums. I understand these traumas are well documented through his medical history and school records.'*

*'Witness of domestic abuse as a child, father would assault him also.'*

*'DL commented that AM had been visited at home with his mother. She appeared to be very controlling and stated that she locks AM in the house when she pops out. The house is a health hazard and a considerable fire risk.'*

*'His father also physically abused him and as a result he spent long periods in care of the local authority.'*

*'Records state that his mother was violent and abusive towards him.'*

Participants had also been sexually abused by family members such as fathers and brothers in addition to others in positions of responsibility such as a substitute teacher.

*‘Father sexually abused and raped her from age 8.’*

*‘There are issues of childhood trauma. PSR notes ‘He said his excessive drinking began when he was a victim of sexual abuse aged 13 years old.’*

*‘Whilst in care was sexually abused by an older man who offered the boys money for sexual acts.’*

*‘Victim of sexual and physical abuse by a substitute teacher when he was aged 11.’*

*‘He described being the victim of childhood sexual abuse at the hands of his female cousin between the age of eight and thirteen.’*

There are several reasons why children with ID/IV are more at risk of sexual abuse including their vulnerability, inability to speak out about what has happened to them, residing in care homes where they are at risk from staff and other residents, that they are often deemed an unfit or unreliable witness so abusive behaviour is not sanctioned and because they lack the cognitive skills to understand or challenge what is happening to them. Allington-Smith et al (2002) cite the risk factors for sexual abuse in children with learning disabilities as ‘multiple carers, care away from the family home in residential schools, respite care, shared care, during transport to and from care or school, continuing need for intimate care, communication problems, sensory impairment, low self-esteem, lack of sexual knowledge, physical disability – inability to escape and emotional distress wrongly attributed to disability.’ It is evident that these risk factors could equally apply to adults with ID/IV especially those in prison or living with other offenders at approved premises.



Head injuries had occurred frequently during early childhood. Some of these injuries appeared to have occurred as a result of accidents but more often due to abusive behaviour by a care giver. There were several data extracts that referred to skull fractures and periods of unconsciousness;

*‘He said that his mother and father were very physically abusive towards him, possible brain damage.’*

*‘Meanwhile W said he was physically abused when he was 6 weeks old by his mother, fracturing his skull and his collar bone.’*

*‘He told me this is how he deals with conflict and believes this is a result of the head injuries he suffered as a child.’*

As discussed in the mental health core theme above, it is possible that traumatic brain injury (TBI) may have contributed to some of these cases ID/IV presentation. Whilst mentioned it was not evident that anyone at the MAPPA meeting had understood the link between TBI and someone’s presentation.

There is some commonality with findings from study one and the issues of neglect and abuse of people with intellectual disabilities is addressed in more detail in the discussion, chapter 7.

### **Sub Theme - Schooling/Educational issues**

Another sub-theme under early life experiences was the experience of the ID/IV group at school or during their education. There were frequent references to people being given a statement of special educational needs as a child, thus assisting in identification of ID as an adult. This is one of the key questions in the LDSQ, (McKenzie & Paxton, 2006). School experiences often involved bullying. Other key themes included exclusion and leaving school early often due to behavioural problems or emotional and social difficulties. Participants were frequently described as truanting and leaving with no qualifications. Learning needs and difficulties also featured in many of the data extracts as follows;

*'Truanted from school, left at 14. He is a statemented child with multiple learning difficulties and needs.'*

*'Truanting resulting in leaving school early. Literacy issues.'*

*'He could not be managed in mainstream schools due to his disruptive and aggressive behaviour. To some extent, some of these behaviours, impulsiveness and poor attention span were a result of his diagnosed ADHD and he had a statement of special educational needs. However he still has some problems reading and writing.'*

*'D indicated that he believes he has a number of issues associated with learning difficulties and dyslexia. He disclosed that he exhibited behavioural difficulties at school which resulted in him being removed from mainstream education.'*

*'You were expelled from school at the age of 15 for violent behaviour after several incidents including punching a teacher and setting a boys hair on fire.'*

Brier (1989) referred to the school failure hypothesis and proposed that school failure can be the first step towards delinquency if the individual has a 'delinquency prone temperament.' Similarly Farrington (2004) identified one of the key risk factors for the early onset of offending as 'low school achievement' and the issue of school failure and the link to offending is addressed in chapter one. Given the high incidence of school failures identified in the thematic analysis, and that the majority of the ID/IV group had the ID school failure variable present this issue will be explored further in the discussion, chapter 7.

### **Main Theme - Offending Behaviour**

A further main theme of offending behaviour was identified from the analysis. The offences committed by the ID/IV group were typical of those committed by other offenders managed by the MAPPA process. In order to be a MAPPA eligible offender the person must be convicted for sexual or violent offences. Many of the ID/IV participants had data extracts that referred to a significant and serious history of offending behaviour. The breadth of offending behaviour ranged from sexual, violent, acquisitive and public order type offences. There were also references to several adjudications whilst in the prison system. Several of the data extracts referred to offences against the Police which may indicate anti-authoritarian views or may suggest a difficulty in the interaction at the point of arrest. Data extracts illustrating the offending behaviour theme are as follows;

*‘Committed ABH on a prison officer sentenced to 2 years custody- pre-cons long history of violent and acquisitive crime, racially aggravated. 46 adjudications for bad behaviour during this sentence – disobeying orders, fighting, assault staff etc.’*

*‘Indecent exposure and breach of SOPO. Long history of previous offending – 14 convictions for 23 cases. Diverse offending including acquisitive, sexual, public order, firearms, offences against property, battery and harassment.’*

*‘Arson reckless as to whether life would be endangered. On the day of the offence offender had been ruminating over the abuse her father had perpetrated against her over the previous 10 years. She wanted to teach her father a lesson. She then purchased some petrol and filled some soft drinks bottles with it. She then drank 4 pints of Guinness at the pub. She went to her father’s flat and poured petrol on his door, then set light to it. She did not realise anyone else may be put at risk.’*

Many studies have examined the prevalence rates of offence types amongst offenders with ID. Simpson and Hogg (2001) included many of these studies when they conducted a systematic review of patterns of offending among people with ID. Whilst Simpson and Hogg (2001) acknowledged the many methodological issues with the studies they were reviewing they did propose five main findings; Firstly that the prevalence of offending for the ID group was no higher than the general population. The second finding was that offending was very rare for people with an IQ below 50. Thirdly that relatively the prevalence of sexual offending, criminal damage and burglary (not including theft) are higher among an ID group of people with an IQ in the ‘borderline range’ than the general population. The fourth finding was that very serious offences including murder or armed robbery were under-represented in this group. Finally Simpson and Hogg (2001) comment that the

‘practices and systems of criminal justice and ID services have a massive impact on the apparent prevalence and distribution of offenders with ID and the types of crimes which they commit.’

It is possible that the ID/IV group which has been identified in this study share more characteristics with the ‘borderline range’ group referred to in Simpson and Hoggs (2001) review. The issue of diagnosis, inclusion and ID/IV is central to this research and is discussed further in chapter 7.

Two further sub-themes were evident under the main theme of offending behaviour, substance misuse and victim known/vulnerable.

### **Sub Theme - Substance Misuse**

A sub-theme of offending behaviour identified by the analysis was substance misuse. Substance misuse in terms of possession of illegal drugs can itself constitute an offence. There were frequent references to the ID/IV participants using and abusing alcohol. Similarly many ID/IV participants were discussed in terms of substance misuse. This included a vast range of substances from cannabis to heroin and cocaine. There were also lots of references to the participants engaging with detoxification programmes. Frequently conditions had been set around reduction or abstinence from drugs. Illustrative data extracts include;

*‘poly drug abuse – cocaine, amphetamines, ecstasy, heroin, LSD and crack. Binge drinking – strong lager and spirits’*

*'Not to consume alcohol/comply with testing. To comply with requirements for addressing drug problems.'*

*'This report stated that he has previously met the criteria for multiple substance misuse syndrome. Address your alcohol problems. Address your drug problems.'*

Often during the discourse around participants use of alcohol and drugs there were references to the way in which the substances affected their behaviour. This most often referred to violent and confrontational behaviour;

*'When released drinks heavily and 'picks fights'.*

*'He stated he can feel frustrated and angry when he drinks which can lead to violence.'*

There are clearly links with the main theme of offending behaviour with both violence as a result of substance misuse and the possession and use of illegal drugs;

*'This needs enforcing to R as he is committing an offence by using cannabis. Index offences involved alcohol certainly, unsure re drug use, although there is no indication. R has a previous for Possession of cocaine.'*

Several data extracts made reference to the impact of substance misuse on the individuals' health and well-being. Clearly there is some overlap with mental health and the impact on well-being. References were made to links to early onset dementia, drug-induced psychosis and head injury as follows;

*'G is uncertain if there is a connection between his head injuries and how this may be affected by the use of alcohol.'*

*'He is on his final warning for exceeding the tolerated alcohol levels. His history of substance abuse and alcohol consumption has contributed to the potential early onset of dementia.'*

*'C has spoken to him about the effect cannabis has especially as he is on anti-psychotic drugs but J doesn't see it as a problem.'*

*'drug induced psychosis'*

As with some of the other themes identified the issues may be more pertinent to the offender group as a whole rather than specific to offenders with ID/IV. However for this ID/IV group there were similar numbers of data excerpts for drug and alcohol misuse.

Lindsay (2013) considered the relationship between alcohol and offending in a group of offenders with ID. Lindsay examined a sample of 477 people with ID who had been referred to forensic ID services. Whilst alcohol use and misuse were lower in people with ID there did appear to be a relationship to offending. Interestingly those with higher rates of alcohol problems were associated with 'histories of a number of offences, psychiatric disturbance in adulthood, psychiatric disturbance in childhood, and experiences of childhood adversity.' Lindsay (2013) also acknowledges that these factors are also risk factors for offending behaviour similar to those identified above. This description is very similar to the issues identified in the ID group for this research and the themes identified by the analysis.

In respect of substance misuse McGillivray & Moore (2001) conducted a study on substance misuse by offenders with mild intellectual disability. They compared 30 young adults with mild ID with a matched group of ID non-offenders with regard to their substance misuse behaviour and knowledge about the substance. They concluded that the ID offending group regularly consumed alcohol and illegal drugs. Similar to Lindsay's (2013) findings the research suggested a link between substance misuse and offending as many had been under the influence of a substance at the point of arrest.

Whilst the prevalence rate of substance abuse amongst the prisoner population in England and Wales may be very high, Singleton, Farrell & Meltzer (1997), offenders with ID may be particularly susceptible to substance misuse. A number of factors have been identified in relation to susceptibility including self-medication, low self-esteem, impaired self-regulation and the desire for social acceptance or indeed how particularly susceptible people with ID may be to peer pressure, Moore and Polsgrove (1991). Plant, McDermott, Chester and Alexander (2011) have also examined substance misuse among offenders in a forensic ID service. Their study of 74 patients found that approximately half the patients in their sample had co-morbid substance misuse and this was equally prevalent in males and females. They also found that a past history of violent offending and a diagnosis of personality disorder were more likely to be present in the group that had the most harmful or dependent drug use. Another interesting finding was that having a past history of parental violence was significantly higher in those with a history of substance misuse. There is clearly overlap between this sub theme and the abuse sub theme.

It is clearly important that the issue of substance misuse is taken into account as a likely and relevant risk factor when working with an ID offender. Plant et al (2011) advocate targeted treatment



programmes for ID offenders and ensuring that substance misuse is taken into account as an important risk factor.

### **Sub Theme – Victim Known or Vulnerable**

Under the main theme offending behaviour the analysis indicated a sub theme of offending against particular victim types namely that the victim was known to the offender or was particularly vulnerable e.g. much younger than the offender or had intellectual disabilities.

Offending behaviour was frequently referred to as having been directed at a family member, especially when discussing violent behaviour. This was sometimes in response to abuse experienced at the hands of a parent when the person was younger. There were also references to other offences against family members. Illustrative data extracts include;

*‘It was explained that of the concern about her previous history of violence against her father and that if she felt cross enough towards C that she herself might become violent.’*

*‘Being managed under MAPPA due to domestic violence concerns against mother, sister and ex-partner. Has previous convictions for violence and burglaries, threats to kill his mother and sister, assault, criminal damage and theft from mother and sister.’*

*‘Current sexual offence is against his mother.’*

The issue of offending against family members may be to do with victim access in that many adults with ID still reside with their parents or other family members if they are not in residential care.

There were several instances of victims' particular vulnerabilities being referred to for example the age of a young child or the fact that they themselves had a learning disability or a mental health diagnosis such as indicated by the following data extracts;

*'Victim had low IQ, Mental health issues and complex emotional and behavioural problems.'* *'Both mothers of the children have learning difficulties themselves. Possibility that D could groom more vulnerable women in the future, despite his difficulties.'*

*'a female child under 13 years.'*

*'Current offence of sexual assault on a female aged 13 at a friend's birthday party.'*

*'Group homes or supported housing, where he has also on occasion assaulted other residents.'*

Gilby, Wolf and Golberg (1989) researched a group of 'mentally retarded' adolescent sex offenders in Canada. They found that in respect of the victims of ID sexual offenders their victims were usually known to them and were mainly other people with ID, and sometimes children or very rarely non-ID adults. In relation to vulnerable victims for those with ID it is foreseeable that they would target vulnerable or known victims as they may not have the requisite social or grooming skills to access more cognitively able victims. It is possible in the case of sexual offending that ID offenders may have viewed child victims as peers or age appropriate due to similar cognitive abilities.

Clearly when considering the risks that the ID/IV offender group present, potential victims are an important consideration. Therefore victim access and the increased likelihood of offending against a family member, vulnerable child or adult or someone who is in close proximity (i.e. fellow residents) should be taken into account during MAPPA.

## **Summary**

This chapter has outlined the rationale for study two. Consideration of the case note review as a methodology was offered in addition to the considerations of selecting thematic analysis as the best method for reviewing the issue of ID/IV within the MAPPA minutes. The main themes and sub themes identified by the analysis have been presented and discussed in respect of the literature. In the next chapter the discussion of the overall research findings and implications are addressed.

## **Chapter 7 – Discussion**

This final chapter draws together the main findings of the research considering the limitations and how the findings relate to previous research. Implications for future research and practice are also considered.

### **Study One**

The first hypothesis, that the prevalence rate for high risk of harm IV offenders will be in the range of 20-30%, was in line with the Loucks (2007) criteria used by the Prison Reform Trust was supported. In relation to prevalence this research found similar rates to other studies depending which of the ID variables were included. However the methodology could have been improved to ensure greater clarity. As this issue is relevant to both studies it is covered in more detail below.

The second differential treatment hypothesis, ‘Offenders identified as having IV (defined as having two or more of the indicators listed in the CRF) will have significantly higher levels of external controls than the non-IV group’ was not supported. The number of external controls such as licence conditions and police led orders was found to be no different between the IV and non-IV groups which may have been attributable to the fact they were all high risk of harm offenders being managed by MAPPA and as such appropriate. There was a significant difference between the ID and Non-ID groups on one of the external controls – Police Lead Orders. Therefore the most disabled groups were more likely to be subject to a ‘Police Lead Order’ which supports the

hypothesis to some extent. However differential treatment is important in the context of assessment, management and intervention being appropriate to the individuals needs.

The third key factors hypothesis, 'the IV group of offenders will have higher levels of key factors such as school disruption, mental health concerns, substance misuse than the non-IV group' was supported to some degree. The IV group was over 5 times more likely to have language problems and twice as likely to have been in care. Significance was almost reached for the key factor of suicide and ISI risk being more relevant to the IV group. These findings raise some key considerations for the ID/IV group. How are the group communicating with CJS professionals? What are the implications for their journey through arrest, court, prison, probation? Do they understand what is happening to them? There was some overlap with themes identified in the thematic analysis; clearly some cases did not understand the CJS or the implications. However in respect of suicide and ISI previous studies appear to indicate that risk factors are similar to the general population, therefore it is important the issue of risk to self is not neglected for ID/IV offenders.

## **Study Two**

The second study used thematic analysis to identify key themes for the ID/IV group. The main themes and sub themes that were identified were 'Intellectual Disability/Vulnerability' and sub themes 'Mental Health' and 'Diversity Considerations,' 'Early Life Experiences' which had sub themes of 'Abusive Experiences' and 'Schooling/Education' and finally 'Offending Behaviour' with the sub themes 'Substance Misuse' and 'Victims Known or Vulnerable.' Unsurprisingly there was

some overlap between studies 1 and 2 in respect of the level of vulnerability the ID/IV had. The ID/IV group were twice as likely to have been in care and over 5 times as likely to have language difficulties. This indicates a very vulnerable group.

However there were some commonalities between the ID/IV offender and general offender group in respect of substance misuse, risk of suicide and ISI and a history of school failure. It is important that these factors are referred to and considered within MAPPA. Similarly the victim profile for the ID/IV group should be properly considered, especially with regards to family members and those in close proximity to the ID/IV offender.

## **School Failure**

Brier's (1989) School Failure Hypothesis, suggests that the school failure experienced by LD adolescents is the first step on the route to delinquency. However Larson (1988) argued that school failure is an effect, rather than a cause of delinquency for ID offenders. Regardless of cause or effect the issue of school failure and educational experiences is very pertinent to the ID/IV group. This issue should routinely be incorporated into MAPPA risk discussions as it is such a relevant variable not only for risk of offending but also for life outcomes. There is a high incidence of school failure amongst the general offender population. But it is a factor that links with other delinquency variables. The Berridge et al (2001) study on the effects of permanent exclusion from school, mentioned above, found that the young people in the study suffered from a range of social and educational disadvantage. These young people had been, more frequently than non-excluded

children, subject to issues such as sexual abuse, parental violence, frequent home moves and homelessness, bereavement and contact with the care system. Clearly these are characteristics shared with the study ID/IV group.

People can 'fail' at school for any number of reasons such as ID, learning difficulties, language and speech difficulties, challenging behaviour, pro-criminal family, bullying, neglect and abuse. Then there are other individual effects such as the impact on self-esteem and the difficulties in later life of finding employment. Therefore it is important not to lose sight of developmental factors including family and educational history when undertaking risk assessment and management work with adult offenders.

## **Traumatic Brain Injury**

The issue of brain injury and associated symptoms and difficulties was apparent in studies 1 and 2. There were 33 cases who had recorded head injury or brain damage in their file information in Study One. Similarly in Study Two the issue of head injury and brain damage and its impact on behaviour was well documented. It is unsurprising that impulsive young men will sustain head injuries whilst engaged in sports, road accidents and fights or that offenders will be vulnerable in respect of abuse both physical and due to drugs and/or alcohol.

In his review of brain injury and its implications for criminal justice, Williams (2010) has identified a high level of TBI (Traumatic Brain Injury) amongst offenders in the UK. In his study of 200 adult

male prisoners over 60% claimed to have suffered TBI. Williams (2012) has undertaken a comprehensive review of TBI and its implications for criminal justice. The review reports a number of pertinent findings including the link between frontal lobe damage and the link to violent criminal behaviour; TBI and increased risk of mental health problems, particularly depression, anxiety and suicidality, drug and alcohol misuse; and in respect of 'life course persistent' LCP and 'adolescent limited' AL offenders, in that LCP offenders had experienced significantly more 'knock out' type head injuries. Clearly there is a large degree of overlap with many of the findings about ID/IV offenders. Are they the same group or different sub-groups? Therefore is it more important to focus on individual needs rather than categorisation?

## **Autistic Spectrum Conditions**

In relation to Autistic Spectrum Conditions (ASC) there was a prevalence rate of 4.4% in the whole sample and 17% of the IV sample. This contrasts with O'Brien and Taylor et al (2010) who established a prevalence rate of 10% of autistic spectrum disorder in their multi-centre study of adults with learning disabilities which they cited as similar to the overall rate of ASD reported among adults with a learning disability who offend (e.g. O'Brien and Bell, 2004). It is interesting to note the presence of ASC offenders within this high risk community sample (MAPPA managed) and whether the increase is due to better identification of ASC? The link between ASC and offending behaviour warrants further investigation as Woodbury-Smith, Clare, Holland and Kearns (2006) found that the rate of offending amongst people with 'high-functioning autism' was very low. Given



the small sample in this study the researchers also advocate the need for a larger scale study in this area.

### **ID/IV and Offending**

In relation to ID/IV and offending, the offence characteristics of the ID/IV population used in this study could have been examined in more detail. Previous research such as Simpson and Hogg (2001) found that amongst an ID population of offenders the incidence of sex offending was higher. Also those more serious offences such as murder or armed robbery were under represented in the IV group. This study established a similar finding in that whilst there were 15 homicides in the non-IV group there were none committed by the IV group. Also proportionally 45% of the IV group had committed sexual offences compared to 41% of the non-IV group. Therefore it is interesting that the ID/IV group were so prevalent in this MAPPA cohort, who present the highest risk and yet amongst them the most serious offences were under represented. It may be that ID/IV offenders are being managed by MAPPA due to their complexity than the actual risk presented. This is an area that warrants further research.

### **Study Issues and Limitations**

In relation to this research there is a possibility that age was a confounding variable as there was a significant difference between the ages of the IV and non-IV groups with the non-IV group being

significantly older, albeit whilst significant the difference was small. As the IV group were younger this may mean that as their offence types were similar they are offending earlier, which is a risk factor for offending longer, (Farrington 2004). However there were also a lot more participants in the non-IV group which could also explain the difference. One way to address this issue would be to undertake further research using age matched samples.

The issue of using MAPPA minutes and files as a data source could also be criticised in terms of the variability of minute taking and file keeping. The data contained within MAPPA files relies on the participants of the meeting having shared relevant information and this being recorded properly. As alluded to in chapter 5 it was hoped that as the research was collecting data from thirteen different MAPPA Boards across a large geographical region and corroborating reports and information from a range of practitioners was being considered this variability would be ameliorated to some degree.

A further limitation of the study was the way in which IV was identified. Fourteen different ID variables were used with a study criterion of two or more of these variables to be present for a case to be in the IV group. The full list of frequencies for these variables is included above in table 4.1. The most frequent IV variable was school failure and the least frequent was an IQ score of fewer than 70 or a psychiatric reference to an ID diagnosis. Therefore within the IV group there could have been variation between the diagnoses of individuals and the group may have been over inclusive. One way to have overcome this may have been to split the IV group into further sub-groups by use of different ID variable configurations. This was undertaken for some analyses but could have been more widely applied. One of the difficulties was that the more strictly defined group was too small to conduct much meaningful analysis.

The issue of ID diagnosis has been widely debated. Webb and Whittaker (2012) looked at the definition of learning disability and concluded ‘Psychologists should not continue to collude with a diagnostic system that excludes vulnerable people from accessing the support they need.’ A debate ensued via the letters page of the BPS’s Psychologist magazine considering the role of IQ testing and the consideration of wider cognitive assessment together with an assessment of individual need. Webb (2012) responded to some of the criticism by stating ‘Moreover, we feel that in our current state of knowledge learning disability is not a condition that can have a precise definition. In terms of human attributes it is more like beauty than height.’

Uzieblo, Winter, Vanderfaeillie, Rossi and Magez (2014) have also commented on the methodological problems that beset ID research within the Criminal Justice System (CJS). Uzieblo et al (2014) refer to the difficulties with the definitions of ID that impact on the prevalence rates cited. As the very concept of ID is fraught with difficulty it is unsurprising that prevalence rates vary so much. The paper also criticises many studies for the lack of detail on diagnosis or a ‘reliance on case files.’ Clearly this was one of the shortcomings of this research as described in the previous section. Albeit the paper also criticises research that has used IQ scores due to the absence of consideration of adaptive functioning. Instead Uzieblo et al (2014) promote the use of the Cattell-Horn-Carroll (CHC) model of intelligence within forensic psychology. Therefore an improvement to this research may have been to utilise the CHC model to establish reliable and valid prevalence data and data for comparison with non-ID groups.

As referred to in chapter 2 the different configurations of learning disability services, mental health, commissioning and social care make accessing services for this client group very difficult. Different

geographical areas configure their services differently leading to something of a lottery for service users. A further issue that may have contributed to the variations identified in this study in approach and efficacy of working with ID offenders are the different configurations within health and social care. During this research there was no forensic community mental health team in Kent yet there was in Sussex. Similarly some community learning disability teams had specific forensic services and other did not. The differences that occurred between Primary Care Trusts have been further compounded by a move to Clinical Commissioning Groups (CCG's), making local variation even more likely. It would be advantageous to investigate whether the outcomes for matched samples managed by different services meant that those with a forensic focus were any more effective at meeting their needs.

### **ID Sub-Group, Practice Implications and Further Research**

For this research the prevalence data matched that of the Talbot (2007), No-One Knows study that looked at those offenders most disadvantaged in the CJS. It is possible that there is a sub-group of offenders whose needs are particularly poorly catered for. The formally diagnosed group of intellectually disabled offenders are theoretically able to access the community ID services provided by health and social care. Indeed the most profoundly disabled offenders should in fact be diverted from the CJS altogether. Whereas those offenders with an IQ under 80 but over 69 are excluded from mainstream services including group work interventions and from any access to community services. It is unclear why this group has been systematically excluded from interventions whilst little has been put in place specifically for them instead? There appears to have been a focus in the

CJS on volume interventions rather than targeted specific interventions to meet individual need. Whilst this could be argued on a cost or resource basis it could not be defended on an ethical basis, particularly when the repercussions such as staying in prison longer are so serious. Even if arguing on a cost or resource basis asking an ID offender to complete an intervention three times with no effect, as described in the data excerpt below, is not defensible. The significant cost of repeat attendance could have been better utilised by providing individual clinical work or to establish specialist alternatives on a national basis.

Holland, Clare and Mukhopadhyay (2002) also argued for the presence of two sub groups of ID offenders in a study examining offending and offender characteristics in a male and female ID population. They described a small group already known to ID services and a second larger group who were often unknown to services and indeed would often not qualify for ID services. Nonetheless they could be considered socially and intellectually disadvantaged. In relation to their demographic characteristics, Holland et al (2002) described them as predominantly male, impulsive, risk taking, substance misuse and having conduct disorder in childhood and social exclusion in adolescence and adulthood. One of the authors' recommendations for working with this group is 'flexible, long-term and multi-agency work.' This sub-group share many of the characteristics of the IV sub-group in this study.

This sub-group of offenders are likely to be more seriously affected than the diagnosed ID group. If this group and their needs were able to be better identified then it may be possible to commission specific services for them. As it is depending on a variety of factors it can be 'the luck of the draw'

that places any individual within the CJS or more appropriate services. During the thematic analysis one of the data excerpts stated;

*'In HMP B has done ETS for 3rd time – Feedback indicates he still doesn't understand anything about his offending behaviour i.e. poor progress. The wing Officers state that he has a hygiene problem and always seems to be short of something and is therefore continually borrowing. He never seems to be happy with anyone in his cell. TI stated that TJ is very institutionalised and also very demanding. These issues resulting in Warning Letters have been addressed; however, TJ's behaviour is becoming more and more demanding. His lack of engagement with staff is also increasing and TJ is becoming more argumentative: his body language is aggressive and he starts to shout when he does not like what is being said to him. This makes him less likely to listen, in turn, interfering with his communication skills which are already limited. I have serious risk concerns should TJ attempt to move on to independent accommodation, at this stage. He presents and admits to being institutionalised, has not had to concern himself with paying bills or seeking a home and has no budgeting or living skills. I feel that he will be unable to cope financially and may seek to re-offend to keep any accommodation. During the last 2 months TJ has participated in ETS but does not grasp the concept of enhanced thinking.'*

This excerpt encapsulates many of the points already made about inappropriate expectations, language and treatment. It also highlights issues of poor practice, where individuals are (unethically) compelled to repeat psychological interventions that do not meet their needs, which borders on being abusive. This type of repetition of interventions could lead to the individual losing self-esteem and self-confidence and prevents their progression through the CJS. In not progressing risk of harm

may actually be increased rather than decreased. This type of bad practice may be due to inadequate training of staff involved in delivering psychological therapies that may be unable to make appropriate adaptations to group or individual interventions that would meet their clinical needs. This may well be linked to the inadequacy of identifying individuals that would warrant such assistance in the first place. One way to address this would be to ensure that ID awareness or skills for working effectively with ID is included in the training of CJS staff. A further way would be to ensure better partnership working with ID services in the community. As referred to above if this sub-group could be better identified commissioning would be better informed. Alternatively if a more informed individualised approach could be taken with all offenders this would negate the need for categorisation.

Overall it appears that it is very difficult to distinguish ID offenders from non-ID offenders or indeed to accurately identify ID at all. Methodological problems abound and there is a great deal of overlap between diagnoses which whilst difficult for psychological staff to consider is nigh on impossible for other professionals involved in MAPPA or the CJS. In order to address these issues it may be better to focus on some of the shared presentational issues rather than the debate about diagnostic criteria. For example the development of speech and language therapy services within the CJS would benefit numerous offenders regardless of a label of ID or non ID. Gregory and Bryan (2009) found that a speech and language therapist seconded to a Youth Offending Team (YOT) could make a significant difference and bring about radical improvements in language and communication skills that enabled young offenders to access YOT interventions, in particular with education and training. The IV group in this research that were 5 times more likely to have language difficulties would clearly benefit from such intervention.

Therefore is it more beneficial to consider one of the benefits of the MAPPA approach in relation to offenders who are most disadvantaged in the CJS which is the individualised approach which could be considered as akin to care planning? The assessment of risk and need in addition to the requirements for adaptation. This could be applied to the 'in-between' sub group of offenders that fall between the mainstream and the diagnosed intellectually disabled. The promotion of the clinical formulation for offenders by the community personality disorder strategy from the Department of Health and Ministry Of Justice (2011) may assist probation staff with this approach.

Similarly in terms of identification it is of paramount importance that the CJS adopts a systematic process of identifying offenders with specific needs such as ID. Wood (2007b) highlighted the importance of consistent representation from mental health and psychology services at MAPPA meetings to ensure appropriate assessment and management. However it is acknowledged that with the budgetary pressure facing the CJS it is unlikely that this would be resourced. Hence there is a need to establish the use of a screening that all CJS staff could utilise such as the LDSQ.

This research has made a unique contribution to the field by examining a high risk of harm, community cohort of ID offenders who are managed by MAPPA in detail. However based on this study there is still a pressing need for further good quality research in this area to inform policy and practice in the following areas; identification, screening and recording, the use of speech and language therapy, adaptations such as 'easy read' and appropriately targeted and accessible group and individual interventions.



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## Appendices

<i>Appendix A</i>	MAPPA Agenda template
<i>Appendix B</i>	MAPPA Minutes template
<i>Appendix C</i>	Data Collection Schedule
<i>Appendix D</i>	Example of the Roehampton University Consent Form (Please note the appendix 1 that this form refers can be found at Appendix F in this document)
<i>Appendix E</i>	Example Letters of Permission from two MAPPA Leads
<i>Appendix F</i>	Case Review Framework (CRF)
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<i>Appendix J</i>	Revised Coding Book for SPSS

*Appendix A*

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**APPENDIX C – Initial MAPP Meeting Agenda**

- 1. Introduction by Chair**
- 2. Confidentiality and Diversity Statement**
- 3. Offender information**
- 4. Attendee introductions and apologies**
- 5. Subject's legal and MAPPA status**
- 6. Summary of referral information**
- 7. Additional information from other agencies**
- 8. Risk to victims**
- 9. Diversity considerations**
- 10. Risk assessment summary**
- 11. Disclosure decision**
- 12. Communication: press and media handling**
- 13. MAPPA Risk Management decision and Plan**
- 14. Human Rights Act validation**
- 15. Update to ViSOR**
- 16. Issues for reporting to the MAPPA SMB**
- 17. Review meeting date**

## *Appendix B*

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### **MAPPA Form C – Initial MAPP Meeting Minutes**

#### **1. Introduction by Chair**

**MAPP Meeting Chair:**

**Minutes completed by:**

#### **2. Confidentiality and Diversity Statement**

##### **Confidentiality Statement**

In working with offenders, victims and other members of the public all agencies have agreed boundaries of confidentiality. The information contained in these MAPP meetings respects those boundaries of confidentiality and is shared under an understanding that:

1) The meeting is called in circumstances where it is felt that the risk presented by the offender is so great that issues of public or individual safety outweighs those rights of confidentiality.

2) These minutes are closed under the Freedom of Information Act 2000 under one or more of the following reasons:

- a) Investigations and proceedings by Public Authorities (S.30 (1)(B));
- b) Health and safety (S.38);
- c) Personal information (S.40);
- d) Information provided in confidence (S.41).

3) The discussions and decisions of the meeting take account of Article 8.2 European Court of Human Rights, with particular reference to:

- a) Public safety;
- b) The prevention of crime and disorder;
- c) The protection of health and morals;
- d) The protection of the rights and freedom of others.

All documentation will be marked RESTRICTED.

**These minutes should not be photocopied or the contents shared outside of the meeting without the agreement of the Chair. Minutes should be kept in the RESTRICTED or CONFIDENTIAL section of agency files.**

If further disclosure within your agency is felt essential, permission should be sought from the Chair of this MAPP meeting and a decision will be made (share on a need-to-know basis, share information which is proportionate and necessary) as to what information can be shared.

##### **Diversity Statement**

The work of MAPPA is committed to equal access to services for all groups, particularly in relation to race, gender, age, religious belief, sexual orientation and disability, and to ensuring that policies and procedures do not draw on stereotypical assumptions about groups or contain any elements that will be discriminatory in outcome. In undertaking its work, the agencies involved in MAPPA will be sensitive and responsive to people's differences and needs and integrate that understanding into the delivery of its function in order to ensure that nobody is disadvantaged as a result of their belonging to a specific social group.

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### **Purpose of level 2 and 3 MAPP Meeting**

The purpose of the meeting is for agencies to share information which:

- Is pertinent to undertaking a multi-agency risk management assessment;
- Identifies the likelihood of re-offending;
- Identifies serious risk of harm issues and imminence;
- Agrees those aspects of behaviour and/or circumstance which are critical to delivering an effective MAPPA Risk Management Plan.

### **3. Offender Information**

**ViSOR reference:**

**Family name:**

**First name:**

**Date of birth:**

**Gender:**

**Ethnicity:**

**Date of meeting:**

**Time of meeting:**

**Venue of meeting:**

### **4. Attendee Introductions and Apologies**

**Apologies / reports sent:**

**Apologies:**

**Invited & did not attend:**

### **5. Subject's Legal and MAPPA Status**

**Current sentences/orders/statutory requirements/changes (with dates):**

**MAPPA Category 1, 2, or 3:**

**Previous relevant convictions (if Category 3):**

### **6. Summary of Referral Information**

### **7. Additional Information from Other Agencies**

### **8. Risk to Victims**

### **9. Diversity Considerations**

### **10. Risk Assessment Summary**

### **11. Disclosure Decision**

**Was disclosure considered? Yes/No**

**Will disclosure take place? Yes/No**

**Reasons & details (if yes – what will be disclosed, who to, by whom and when by):**



**12. Communication: Media and Press Handling**

**13. MAPPA Risk Management Decision and Plan**

**RMP Decision:**

**Planned actions to be taken:**

Who What When

**Does this case require ongoing management at level 2/3? Yes/No**

**14. Human Rights Act Validation**

**15. Update to ViSOR**

**16. Issues for Reporting to the MAPPA SMB**

**17. Review Meeting Date**

*Appendix C*

**Data Collection Schedule**

Data were collected as follows:

<b>Probation Trust</b>	<b>Office</b>	<b>MAPPA Level</b>	<b>Dates from</b>	<b>to</b>
Surrey	Redhill	2	19/03/2010	26/03/2010
Sussex	Brighton	2 & 3	23/03/2010	21/05/2010
Thames Valley	Kidlington Police Headquarters	3	28/04/2010	29/04/2010
Hampshire	Alresford, Police MAPPA Office	3	01/05/2010	02/07/2010
Thames Valley	Reading	2	09/08/2010	19/08/2010
Hampshire	Aldershot	2	08/10/2012	23/11/2012
Kent	Maidstone	2	16/02/2012	10/01/2013
Kent	Tunbridge Wells	2	18/12/2012	11/01/2013
Kent	Maidstone Police Headquarters	3	16/02/2012	11/01/2013

*Appendix D*

Roehampton University Ethical Consent Form Example



*ETHICS BOARD*

**PARTICIPANT CONSENT FORM**

**Title of Research Project:** Intellectual Disabilities – Policy and Practice within Multi Agency Public Protection Panel Arrangements (MAPPA)

**Brief Description of Research Project:**

This research is being undertaken for a PsychD in Forensic Psychology at Roehampton University. The researcher is employed by Kent Probation.

The purpose of the proposed investigation is to establish the prevalence rates of people with intellectual disabilities who are managed by level 3 MAPPA in the South East Probation Region. The Prison Reform Trusts' No One Knows report, (Talbot, 2007) highlights experiences of offenders with Intellectual Disabilities (ID) in custody. Similarly the recently published Bradley Report, April 2009 has reviewed the experiences of people with mental health problems or intellectual disabilities in the Criminal Justice System (CJS). Both reports note the paucity of appropriately targeted resources for offenders with intellectual disabilities. A further issue relates to the lack of consensus of assessment criteria for offenders with intellectual disabilities/difficulties. Due to this, a number of issues pertaining to offender groups with intellectual difficulties are not being properly identified. It is thus perhaps unsurprising that the range of presentational issues such as impulsivity, language difficulties, poor empathy, difficulty understanding and following instructions leads them into difficulties within the CJS. They may also be exposed to a more punitive response from staff and suffer from a lack of appropriate resources. Longitudinal studies, such as the Cambridge study by David Farrington (1995), have established a clear link between delinquency and low IQ. The study will also aim to establish whether offenders with ID are treated differentially to offenders who do not have ID within the context of MAPPA.

A Case Review Framework (CRF) has been developed to examine pertinent variables, please see attached appendix 1. The CRF will be applied to initial (first set) of MAPPA minutes and the most recent set of MAPPA minutes in each case. Any mental health reports, pre-sentence reports and offending behaviour programme reports will also be consulted.

Data Collection – data would be collected via a stand alone lap top computer using SPSS (Statistical Package for Social Sciences) version 16. The data would be stored on an encrypted password protected memory stick. This data stick has

been supplied by Kent Probation Service and adheres to Government standards for secure data storage. No data will be stored on the lap top hard drive. A back up copy of raw data will be stored under the researcher's personal folder on the Kent Probation secure server which is only accessible by the researcher. Again the server and data stored on it are in line with National Probation Service Information Security Policy and meet Government standards for the secure storage of information. Data will be securely destroyed after 6 years.

Anonymity - Each case would be allocated a number and any identifying information would be kept separately as a key. The key to case identification would be stored securely and only accessed by the researcher.

The potential benefits to areas are as follows:

To establish whether MAPPA are managing a similar proportion of offenders who have ID to the rates suggested by research for other areas of the Criminal Justice System.

The opportunity to learn more about offenders with ID who are managed by MAPPA.

**Investigator**

**Contact Details:** Name: Tania Tancred  
Senior Forensic Psychologist  
Kent Probation Area  
56 – 58 College Road  
Maidstone  
Kent  
ME15 6SJ  
Email: tania.tancred@kent.probation.gsi.gov.uk  
Telephone: 01622 697121 or 07736 665136

**Consent Statement:**

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name [REDACTED]

Signature ... [REDACTED]

Date .....7<sup>th</sup> October 2009.....

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to

contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

**Director of Studies Contact Details:**

Name: Professor Robert Edelman  
School: Human and Life Sciences  
University Address: Whitelands College,  
Holybourne Avenue, London SW15 4JD  
Email: R.Edelman@roehampton.ac.uk  
Telephone: N/A

**Dean of School Contact Details:**

Name: Michael Barham  
School: Human and Life Sciences  
University Address: Whitelands College,  
Holybourne Avenue, London SW15 4JD  
Email: M.Barham@roehampton.ac.uk  
Telephone: 020 8392 3620

*Appendix E*

Example Letters of Permission from MAPPA Leads

**Thames Valley Probation**



Our Ref: [REDACTED]

Tania Tancred  
Senior Forensic Psychologist  
Kent Probation  
56-58 College Road  
Maidstone  
Kent  
ME15 6SJ

8 October 2009

Dear Tania

On behalf of Thames Valley Probation I am writing to confirm permission for access to Area case records in relation to the Intellectual Disabilities - Policy and Practice within Multi Agency Public Protection Panel Arrangements (MAPPA) research.

This is subject to no information being removed or collated that could identify any individual.

Yours sincerely



Director of [REDACTED]

- RESTRICTED -

Kent Probation



Tel: [REDACTED]

Fax: [REDACTED]

Email [REDACTED]



*Changing Lives  
Reducing Crime*

Our Ref: [REDACTED]

Your Ref:

Date: 1<sup>st</sup> October 2009

To Whom It May Concern:

My name is [REDACTED] and I am the Director of Offender Management in Kent Probation. I am the Senior Manager responsible for Multi Agency Public Protection Arrangements in Kent.

I give permission for Tania Tancred, Senior Psychologist, to access the level 3 MAPPA case files and the level 2 MAPPA case files in our Maidstone office in my area for the purpose of conducting a research project. The research is entitled Intellectual Disabilities – Policy and Practice within Multi Agency Public Protection Arrangements and is for the PsychD in Forensic Psychology qualification.

I understand that I am free to withdraw my permission at any point and that I will be kept informed by the researcher on the progress of the research.

Yours sincerely



Director of [REDACTED]

- RESTRICTED -

*Appendix F***Appendix 1****Case Review Framework**

The following case review framework lists the variables that appear on the SPSS data set. Items that have been coded using the ICMS coding systems have been indicated.

**GENDER CODES**

<b>CODE</b>	<b>DESCRIPTION</b>
M	Male
F	Female
T	Transgender

**ETHNICITY CODES (ICMS)**

<b>CODE</b>	<b>DESCRIPTION</b>
A3	Asian or Asian British – Bangladeshi
A1	Asian or Asian British – Indian
A9	Asian or Asian British – Other
A2	Asian or Asian British - Pakistani
B2	Black or Black British – African
B1	Black or Black British – Caribbean
B9	Black or Black British -Other
O1	Chinese
M9	Mixed – Other
M3	Mixed – White and Asian
M2	Mixed – White and Black Asian
M1	Mixed – White and Black Caribbean
O9	Other Ethnic Group
NS	Refusal
W1	White - British
W2	White – Irish
W9	White - Other

**DOB**

Date of Birth recorded as dd.mm.yyyy



### **MAPPA LEVEL**

<b>CODE</b>	<b>DESCRIPTION</b>
1	MAPPA Level 1
2	MAPPA Level 2
3	MAPPA Level 3

### **MAPPA CATEGORY**

<b>CODE</b>	<b>DESCRIPTION</b>
1	MAPPA Category 1
2	MAPPA Category 2
3	MAPPA Category 3

### **CURRENT OFFENCE**

Three columns have been allowed for this as there are often concurrent charges. This information will initially be recorded verbatim as the ICMS coding system lists over 1000 possible offences under legal acts. This level of detail is not required. Therefore some suggested categorisations are suggested below. It may also be helpful to include some detail about the circumstances of the offence? Also victim information i.e. who were offences against if not obvious from the charge?

<b>CODE</b>	<b>DESCRIPTION</b>
V	Violence – including ABH, GBH, Assault
DV	Domestic Violence
SC	Sexual – including Sexual offences against children
SA	Sexual – including sexual offences against adults
M	Murder or Manslaughter
AO	Acquisitive Offences – theft,
A	Arson
R	Robbery
F	Firearms offences

### **SENTENCE (ICMS)**

<b>CODE</b>	<b>DESCRIPTION</b>
54	Community Order CJA 2003
55	Deferred Sentence CJA 2003
56	Suspended Sentence Order CJA 2003
58	Standard Determinate Custody CJA 2003
59	Extended Public Protection CJA 2003
60	Indeterminate Public Protection CJA 2003

38	Intermittent Weekday Custody CJA 2003
39	Intermittent Weekend Custody CJA 2003
57	Custody Plus CJA 2003
111	Immediate Custody Pre CJA 2003
112	Suspended Custody Pre CJA 2003
113	SSSO Pre CJA 2003
114	YOI Pre CJA 2003
115	CS/CPO Pre CJA 2003
116	Probation/CRO Pre CJA 2003
118	Probation/CRO + Groupwork Pre CJA 2003
119	Probation/CRO + Other Pre CJA 2003
120	Supervision Order Pre CJA 2003
121	SO + SA Pre CJA 2003
124	Deferred
127	Combination Order/CPRO
128	CPRO + Groupwork
129	Combination Order/CPRO + Other
131	Curfew Order
132	Custody + Supervision (Sex)
133	Custody + Supervision (Violent)
134	Detention & Training Order
135	Drug Treatment & Testing Order
136	Parenting Order

### **SENTENCE LENGTH**

This will be written in free text as sometimes sentences are recorded in days or in months and years i.e. 1y 2d or 386d

### **CJA 2003 REQUIREMENTS (ICMS)**

<b>CODE</b>	<b>DESCRIPTION</b>
3	Residential
7	Accredited programme (see below)
G	Drug Rehabilitation
H	Alcohol treatment
M	Curfew
N	Attendance centre
P	Mental health treatment
Q	Specified activity (see below)
R	Prohibited activity (see below)
W	Unpaid work
X	Exclusion (see below)
Y	Supervision

**CJA 2003 EXCLUSIONS (ICMS)**

<b>CODE</b>	<b>DESCRIPTION</b>
01	Exclusion from a named football stadium
02	Exclusion from named public house(s)
03	Excluded from a particular area of town
04	Exclusion from the area of a victim's home or workplace
05	Exclusion from named swimming pool, leisure centre, playground etc or from a half mile radius of named schools
06	Exclusion from a particular area which appears to have been targeted for burglary
07	Exclusion from a named store or shopping area
08	Other

**CJA 2003 PROHIBITED ACTIVITIES (ICMS)**

<b>CODE</b>	<b>DESCRIPTION</b>
01	Attending any football match
02	Entering any public house or licensed premises
03	Associating with named individual(s)
04	Approaching or communicating with victim and/or family member
05	Taking work or organised activities which will involve a person
06	Approaching or communicating with any child
07	Residing in the same household as any child
08	Other

**CJA 2003 SPECIFIED ACTIVITIES (ICMS)**

<b>CODE</b>	<b>DESCRIPTION</b>
01	Victim reparation / mediation
03	Education, training and employment
04	Finance
05	Accommodation
07	Other

### **COMMUNITY OFFENDING BEHAVIOUR PROGRAMME (ICMS)**

<b>CODE</b>	<b>DESCRIPTION</b>
01	Think First
03	One to one
04	CSB (Cognitive Skills Booster)
06	ART (Aggression Replacement Therapy)
07	IDAP (Integrated Domestic Abuse Programme)
09	SOGP (Sex Offender Groupwork Programme)
13	OSAP (Substance Abuse Programme)
15	DID (Drink Impaired Drivers)
19	I-SOTP (Internet Sex Offender Treatment Programme)

### **PRISON OFFENDING BEHAVIOUR PROGRAMMES**

<b>CODE</b>	<b>DESCRIPTION</b>
01	Thinking Skills
02	Sex Offender Treatment
03	Adapted Sex Offender Treatment
04	Domestic Abuse
05	Anger Management
06	Substance Misuse

### **TIME MANAGED AT LEVEL 3 MAPP**

This data will be recorded as separate dates – date first registered as level 3 MAPP and date registration ended – there will be three separate columns for this to allow for increases and reductions in risk i.e. to be de-registered and re-registered from level 3 MAPP. Dates are recorded in dd.mm.yyyy format

### **TIME MANAGED AT LEVEL 2 MAPP**

This data will be recorded as separate dates – date first registered as level 2 MAPP and date registration ended – there will be three separate columns for this to allow for increases and reductions in risk i.e. to be de-registered and re-registered from level 2 MAPP. Dates are recorded in dd.mm.yyyy format

## **INTELLECTUAL DISABILITY INDICATORS**

### **PSYCHIATRIC DIAGNOSIS OF ID**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No Psychiatric Information relating to ID
1	Psychiatric Diagnosis of ID
2	No Psychiatric Reports

### **PSYCHOLOGICAL DIAGNOSIS OF ID**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No Psychological Information relating to ID
1	Psychological Diagnosis of ID
2	No Psychological Reports

### **COGNITIVE IMPAIRMENT**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No Indication of Cognitive Impairment
1	File Indication of Cognitive Impairment

### **HEAD INJURY**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No Indication of Head Injury
1	File Indication of Head Injury

### **BRAIN DAMAGE**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No Indication of Brain Damage
1	File Indication of Brain Damage

### **SPECIAL SCHOOL**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No File Indication of Special School
1	File Indication of Special School
2	Evidence of Statement of Special Educational Needs

### **SCHOOL FAILURE**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No Evidence of disruption to education
1	Ever played truant
2	Ever suspended
3	Ever expelled
4	Disrupted due to ill health

### **ID RESIDENTIAL HOME**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No evidence of supported living arrangements
1	Previous history of supported living
2	Currently in supported living arrangement
3	Awaiting a place in supported living

### **WAIS SCORE UNDER 70**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No WAIS
1	WAIS score under 70

### **WAIS SCORE UNDER 80**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No WAIS
1	WAIS score under 80

### **WASI SCORE UNDER 70**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No WASI
1	WASI score under 70

### **WASI SCORE UNDER 80**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No WASI
1	WASI score under 80

### **ID TEAM ENGAGEMENT**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No indication ever engaged with ID team

1	File indication of previous history with ID team
2	File indication of current involvement with ID team
3	Awaiting or referred to ID team

### **ID OTHER**

Free text to record any other file indication of ID e.g. a discussion in the body of the minutes.

### **RISK FACTORS**

This is currently a free text field and will be recorded on a separate text sheet per case to capture all of the factors identified by the MAPP.

### **RISK OF HARM**

CODE	DESCRIPTION
1	Low
2	Medium
3	High
4	Very High

### **OASys RISK OF HARM TO CHILDREN**

CODE	DESCRIPTION
1	Low
2	Medium
3	High
4	Very High

### **OASys RISK OF HARM TO THE PUBLIC**

CODE	DESCRIPTION
1	Low
2	Medium
3	High
4	Very High

### **OASys RISK OF HARM TO A KNOWN ADULT/ADULTS**

CODE	DESCRIPTION
1	Low
2	Medium
3	High
4	Very High

### **OASys RISK OF HARM TO STAFF**

<b>CODE</b>	<b>DESCRIPTION</b>
1	Low
2	Medium
3	High
4	Very High

### **MENTAL HEALTH**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No Mental Illness
1	Depression
2	Anxiety
3	Personality Disorder
4	Schizophrenia
5	Psychopathy – PCL-R
6	ADHD (ADD)

### **POLICE RESTRICTIVE ORDERS**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No orders in place
1	SOPO Sex Offender Prevention Order
2	RHO Risk of Harm Order
3	Disqualification Order
4	VOO Violent Offender Order
5	SOO Sex Offender Order (pre-dates SOPO)

### **SEX OFFENDER REGISTRATION PERIOD**

<b>CODE</b>	<b>DESCRIPTION</b>
0	Not on the Sex Offender Register
1	1 Year
2	2 Years
5	5 Years
7	7 Years
Con	Length of Conditional Discharge
Life	Indefinite period - life

### **SUBSTANCE MISUSE**

This item will record any mention of substance misuse current or historic.

<b>CODE</b>	<b>DESCRIPTION</b>
-------------	--------------------



0	No substance misuse issues
1	Heroin
2	Amphetamines
3	Cannabis
4	Cocaine
5	Ecstasy
6	Abuse of prescription medication

### **ALCOHOL MISUSE**

This item will record any mention of alcohol misuse current or historic

<b>CODE</b>	<b>DESCRIPTION</b>
0	No alcohol misuse issues
1	Alcohol Issues

### **PARENTING**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No information about parenting
1	Father involved in crime
2	Parents involved in crime
3	Parental Alcoholism
4	Parenting Style i.e. harsh, critical, lax, punitive etc.

### **SOCIAL SKILLS**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No reference to social skills in file
1	Social skills deficits
2	Impulsive
3	Inattentive
4	Aggressive

Further information to be recorded in free text and analysed for any themes.

### **LANGUAGE ISSUES**

<b>CODE</b>	<b>DESCRIPTION</b>
0	No issues with language mentioned in file
1	Language delays developmental
2	Current language difficulties

The free text sheet will also prompt for any relevant historical factors that could not be collated as above.

*Appendix G*

**Criminal Justice Act Requirements**

The Criminal Justice Act 2003 made major changes to the existing custodial and Non-custodial sentences and had significant impact upon the work of the Probation and Prison Services.

The Act created a single Community Sentence called the Community Order for offences committed on or after 4 April 2005. The Order replaced all existing Community Orders. The Order gave Courts much greater flexibility in sentencing allowing them to give more appropriate sentences tailored to each individual offender.

Judges and Magistrates are able to give a Community Order with one or more Requirements depending on the seriousness of the offence and the potential for risk of harm and reoffending that the offender poses. Low seriousness and low risk offenders may be sentenced to a Community Order with just one requirement, high seriousness and high risk offenders three or more requirements.

There are 12 requirements that can be used to make up a community order and judges can sentence an offender to any combination from the following 12 requirements:

1. **Community Payback** (Previously known as community service). This involves demanding and constructive activities such as removing graffiti, making public places safer or conservation work. The local community benefit from the work and the public can suggest projects for offenders to undertake.
2. **Activity** (e.g. this may include improving basic skills such as reading, writing and numeracy) or addressing alcohol or drug-misuse.
3. **Programme** (these are aimed at changing an offenders' thinking and behaviour. E.g. the enhanced Thinking Skills Programme makes offenders realise the consequences of their actions and teaches them to make less impulsive decisions in the future.) There are also specific programmes for Domestic violence offenders and those convicted of sexual offences.
4. **Prohibited Activity** (Offenders may be ordered not to take part in certain activities like attending football matches. If they do not comply with this they will be sent back to the courts for re-sentencing.)
5. **Curfew** (An offender may be ordered to stay at a particular location for certain hours of the day or night. Curfews help to add structure to an offenders life and break the cycle of offending. Offenders placed under a curfew will normally wear an electronic tag during this part of their sentence.)

6. **Exclusion** (An offender may be prohibited from certain areas (For up to 2 years) and may have to wear an electronic tag during that time.)

7. **Residence** (An offender may be required to live in a specified place such as approved premises /hostel)

8. **Mental Health Treatment** (the court may decide, after taking advice from a health professional that an offender's sentence should include mental health treatment.)

9. **Drug rehabilitation** (this is appropriate for offenders whose crime is linked to drug abuse. Offenders may be required to go on a Drug rehabilitation programme. Programmes usually last between 6 months and 3 years.)

10. **Alcohol rehabilitation** (this is appropriate for offenders whose crime is linked to alcohol abuse)

11. **Supervision** (An offender may be required to attend appointments with an Offender manager or probation officer for up to 3 years. The focus and frequency of the supervision will be specified by the judge and a specific programme of work to reduce the risk of harm and re-offending will be delivered.

12. **Attendance Centre** (For offenders under 25, the court can order the offender to spend between 12 and 36 hours at an attendance centre. Here offenders can address their offending behaviour in a group environment while imposing a restriction on their leisure time.)

The Requirements are also available to the Suspended Sentence Order.

*Appendix H*

Standard licence conditions

- 2.1 Examples of offenders who should be subject to these conditions include those standard determinate sentence prisoners released under the provisions of the Criminal Justice Act 2003 (2003 Act), short term determinate sentence prisoners serving 12 months and over but less than 4 years under the Criminal Justice Act 1991 (1991 Act), long term determinate sentence prisoners serving 4 years and over under the 1991 Act, extended sentence prisoners sentenced before and after 14 July 2008, and DCR prisoners who are released pursuant to the arrangements in s50A 1991 Act.
- 2.2 In order to ensure consistent treatment of cases, the menu of licence conditions derived from the Criminal Justice (Sentencing) (Licence Conditions) Order 2005 (2005 Order) is also used as guidance for licence conditions for those determinate sentenced offenders who fall to be released under the provisions of the Criminal Justice Act 1991.
- 2.3 Offenders serving a life sentence are released on licence pursuant to section 28(5) of the Crime (Sentences) Act 1997. Those serving an IPP sentence are also released under the 1997 Act as amended by Schedule 18 to the Criminal Justice Act 2003.
  - i) *To keep in touch with your supervising officer in accordance with any instruction you may be given;*
  - ii) *If required, to receive visits from your supervising officer at your home/place of residence (e.g. an Approved Premises);*
  - iii) *To reside permanently at an address approved by your supervising officer and notify him/her in advance of any proposed change of address or any proposed stay (even for one night) away from that approved address;*
  - iv) *Undertake only such work (including voluntary work) approved by your supervising officer and notify him or her in advance of any proposed change;*
  - v) *Not to travel outside the United Kingdom unless otherwise permitted by your supervising officer (permission for which will be given in exceptional circumstances only) or for the purpose of complying with immigration/deportation requirements;*
  - vi) *To be well behaved, not to commit any offence and not to do anything which could undermine the purpose of your supervision, which is to*

*protect the public, prevent you from re-offending and help you to re-settle successfully into the community.*

*Appendix I*

Additional Licence Conditions

REQUIREMENTS	LICENCE CONDITIONS
<b>1. Contact Requirement</b>	<p>(a) Attend all appointments arranged for you with [... INSERT NAME ...], a psychiatrist/psychologist/medical practitioner and co-operate fully with any care or treatment they recommend.</p> <p>(b) Receive home visits from [ <b>insert name</b>] Mental Health Worker</p>
<b>2. Prohibited Activity Requirement</b>	<p>(a) Not to undertake work or other organised activity which will involve a person under the age of ..., either on a paid or unpaid basis without the prior approval of your supervising officer;</p> <p>(b) Not to use directly or indirectly any computer, data storage device or other electronic device (including an internet enable mobile telephone) for the purpose of having access to the Internet or having access to email, instant messaging services or any other on line message board/forum or community without the prior approval of your supervising officer. You must allow a responsible officer reasonable access, including technical checks to establish usage.</p> <p>(c) Not to own or possess or permit in your address any computer without the prior approval of your supervising officer.</p> <p>(d) Not to own or possess more than one mobile phone or SIM card without the prior approval of your supervising officer and to provide your supervising officer with details of that mobile telephone, including the IMEI number and the SIM card that you possess.</p> <p>(e) Not to own or possess a mobile phone with a photographic function without the approval of your supervising officer</p> <p>(f) Not to own or use a camera without the approval of your supervising officer</p>
<b>3. Residency Requirement</b>	<p>(a) To permanently reside at (name and address e.g. an approved premises) and must not leave to reside elsewhere, even for one night, without obtaining the prior approval of your supervising officer; thereafter must reside as directed by your supervising officer.</p>

REQUIREMENTS	LICENCE CONDITIONS
<b>4. Prohibited Residency Requirement</b>	(a) Not to reside (not even to stay for one night) in the same household as any child under the age of ... without the prior approval of your supervising officer
<b>5. Prohibited Contact Requirement</b>	<p>(a) Not seek to approach or communicate with [INSERT NAME OF VICTIM AND/OR FAMILY MEMBERS] without the prior approval of your supervising officer and/or the name of appropriate Social Services Department.</p> <p>(b) Not to have unsupervised contact with children under the age of .... without the prior approval of your supervising officer and [INSERT NAME OF APPROPRIATE SOCIAL SERVICES DEPARTMENT]</p>
<b>6. Programme Requirement</b>	<p>(a) To comply with any requirements specified by your supervising officer for the purpose of ensuring that you address your alcohol/drug/sexual/gambling/solvent abuse/anger/debt/prolific/offending behaviour problems at the [NAME OF COURSE/CENTRE].</p> <p>(b) Participate in a prolific or other priority offender project (PPO) [SPECIFY WHICH] and, in accordance with instructions given by or under the authority of your supervising officer attend all specified appointments with your supervising officer and any other agencies for the purpose of ensuring that you address your offending behaviour for the duration of the programme.</p>
<b>7. Curfew Requirement</b>	<p>(a) Confine yourself to an address approved by your supervising officer between the hours of [TIME] and [TIME] daily unless otherwise authorised by your supervising officer. This condition will be reviewed by your supervising officer on a [WEEKLY/MONTHLY/ETC] basis and may be amended or removed if it is felt that the level of risk that you present has reduced appropriately.</p> <p>(b) Confine yourself to remain at [CURFEW ADDRESS] initially from [START OF CURFEW HOURS] until [END OF CURFEW HOURS] each day, and, thereafter, for such a period as may be reasonably notified to you by your supervising officer; and comply with such arrangements as may be reasonably put in place and notified to you by your supervising officer so as to allow for your whereabouts and your compliance with your curfew requirement be monitored [WHETHER BY ELECTRONIC MEANS INVOLVING YOUR WEARING AN</p>

REQUIREMENTS	LICENCE CONDITIONS
	ELECTRONIC TAG OR OTHERWISE].
<b>8. Exclusion Requirement</b>	<p>(a) Not to enter the area of [CLEARLY SPECIFIED AREA], as defined by the attached map without the prior approval of your supervising officer.</p> <p>(b) Not to enter [NAME OF PREMISES/ADDRESS/ROAD] without the prior approval of your supervising officer.</p> <p>(c) Not to enter or remain in sight of any [CHILDREN'S PLAY AREA, SWIMMING BATHS, SCHOOL ETC] without the prior approval of your supervising officer.</p>
<b>9. Supervision Requirement</b>	<p>(a) On release to be escorted by police to Approved Premises</p> <p>(b) Report to staff at [NAME OF APPROVED PREMISES/POLICE STATION] at [TIME/DAILY], unless otherwise authorised by your supervising officer. This condition will be reviewed by your supervising officer on a [WEEKLY/MONTHLY/ETC] basis and may be amended or removed if it is felt that the level of risk you present has reduced appropriately.</p> <p>(c) Provide your supervising officer with details [SUCH AS MAKE, MODEL, COLOUR, REGISTRATION] of any vehicle you own, hire for more than a short journey or have regular use of, prior to any journey taking place.</p> <p>(d) Notify your supervising officer of any developing intimate relationships with women/men.</p>
<b>10. Non- Association Requirement</b>	<p>(a) Not to contact or associate with [NAMED OFFENDERS/NAMED INDIVIDUAL] without the prior approval of your supervising officer.</p> <p>(b) Not to contact or associate with a known sex offender other than when compelled by attendance at a Treatment Programme or when residing at approved premises without the prior approval of your supervising officer.</p> <p>(c) Not to contact directly or indirectly any person who is a serving or remand prisoner or detained in State custody, without the prior approval of your supervising officer</p> <p>(d) Not to associate with any person currently or formerly</p>



REQUIREMENTS	LICENCE CONDITIONS
	associated with [NAME OR DESCRIBE SPECIFIC GROUPS OR ORGANISATIONS] without the prior approval of your supervising officer.

## Appendix J

**Revised Coding Book for SPSS Data**

<b>Variable description and SPSS Variable Name</b>	<b>Current Coding – to be changed</b>	<b>Coding Instructions</b>
Identification Number ID	No ID number had been used just used column number	Number assigned to each case e.g. K1, SX2 etc
Location	none	1=TV 2=Kent 3=Sussex 4=Surrey 5=Hampshire
Gender	F = Female M = Male T = Transgender	1 = Female 2 = Male 3 = Transgender
Ethnicity	A1 = Asian or Asian British Indian A2 = Asian or Asian British Pakistani A3 = Asian or Asian British Bangladeshi A9 = Asian or Asian British Other B1 = Black or Black British Caribbean B2 = Black or Black British African B9 = Black or Black British Other M1 = Mixed White and Black Caribbean M2 = Mixed White and Black Asian M3 = Mixed White and Asian M9 = Mixed Other NS = Refusal O1 = Chinese O9 = Other ethnic group W1 = White British W2 = White Irish W9 = White Other	1 = Asian (A1 – A9) 2 = Black (B1 – B9) 3 = Mixed Race (M1 – M9) 4 = White (W1 – W9) 5 = Other (O1, O9) 6=Refusal (NS)
Age	Currently DOB – need to calculate from DOB to date of data collection	Age in years
MAPP Level	Levels 1, 2, 3	Unchanged
MAPP Category	Levels 1, 2, 3	Unchanged

Current Offence	This is currently a free text box, next to the coded box from ICMS. Recoded to collapsed categories	1 = Homicide 2 = Offences against the person violence 3 = Sexual offences 4 = Burglary 5 = Robbery 6 = Theft and handling 7 = Fraud and forgery 8 = Criminal damage 9 = Drugs offences 10 = Other (including public order, motoring and other) 11 = Sexual and violent offences
Sentence	1 = Conditional Discharge 111 = Immediate Custody Pre CJA 2003 112 = Suspended Custody pre CJA 2003 113 = SSSO Pre CJA 2003 114 = YOI pre CJA 2003 115 = CS/CPO Pre CJA 2003 116 = Probation/CRO Pre CJA 2003 118 = Probation/CRO + Groupwork pre CJA 2003 119 = Probation/CRO + Other pre CJA 2003 120 = Supervision Order pre CJA 2003 121 = SO + SA Pre CJA 2003 122 = Fine 124 = Deferred Pre CJA 2003 127 = Combination Order/CPRO + Other Pre CJA 2003 128 = CPRO + Groupwork Pre CJA 2003 129 = Combination Order/CPRO + Other Pre CJA 2003 130 = Compensation costs 131 = Curfew Order Pre CJA 2003 132 = Custody + Supervision Sex Pre CJA 2003 133 = Custody + Supervision (Violent) Pre CJA 2003 134 = Detention & Training Order Pre CJA 2003 135 = Drug Treatment & Testing Order Pre	1 = Custodial sentence 2 = Community sentence 3 = Life or IPP sentence 4 = YOI sentence

	2003 136 = Parenting Order Pre CJA 2003 2 = Life sentence 3 = Supervision Order 38 = Intermittent Weekday Custody CJA 2003 4 = YOI 5 = Hospital Order 54 = Community Order CJA 2003 55 = Deferred Sentence CJA 2003 56 = Suspended Sentence Order CJA 2003 57 = Custody Plus CJA2003 58 = Standard Determinate Custody CJA 2003 59 = Extended Public Protection CJA 2003 6 = Caution 60 = Indeterminate Public Protection CJA 2003	
Sentence Length Sentleng	Currently a qualitative description	Sentence Length in months number – recoded to sentgrp below
Sentence Group Sentgrp	none	1= 0-2 years 2= 3-6 years 3= 7-10 years 4=11+ years 5=Bail 6=Hospital
CJA2003 Requirements	3 = Residential 7 = Accredited Programme G = Drug Rehabilitation H = Alcohol Treatment M = Curfew N = Attendance Centre P = Mental Health Treatment Q = Specified Activity W = Unpaid Work X = Exclusion Y = Supervision	Number of CJA requirements – total to include all exclusions, prohibited activities and specified activities below
Exclusions linked to requirements	01 = Exclusion from a named football stadium 02 = Exclusion from a named public house 03 = Exclusion from a particular area of	Number of exclusions - As CJA

Exclusions	town 04 = Exclusion from the area of the victims home or workplace 05 = Exclusion from a named swimming pool, leisure centre, playground or from a half a mile radius of named schools 06 = Exclusion from a particular area which appears to have been targeted for burglary 07 = Exclusion from a named store or shopping area 08 = Other	
Prohibited Activity linked with CJA requirements ProhibitedActivity	01 = Attending any football match 02 = Entering any public house or licensed premises 03 = Associating with named individual(s) 04 = Approaching or communicating with victim and/or family member 05 = Taking work or activities which involve a person under 16 06 = Approaching or Communicating with any child 07 = Residing in the same household as any child 08 = Other	Number of prohibited activities - As CJA
Specified Activity linked with CJA requirements SpecifiedActivity	01 = Victim reparation/mediation 03 = Education, Training and Employment 04 = Finance 05 = Accommodation 07 = Other	Number of specified activities - As CJA
Currently in community or custody Custcom	0 = Community 1 = Custody 2 = Special Hospital	1 = Community 2 = Custody 3 = Special Hospital
Community Offending Behaviour Programmes COBPs	00 = Refused Programmes/Denier 001 = Assessed as not suitable for programmes 01 = Think First 03 = One to One 04 = Cognitive Skills Booster 06 = Aggression Replacement Therapy 07 = Integrated Domestic Abuse Programme 09 = Thames Valley Sex Offender Groupwork Programme	Number of programmes attended

	13 = OSAP Substance Misuse 15 = DIDS Drink Impaired Drivers 19 = Internet Sex Offender Treatment Programme	
Prison Offending Behaviour Programmes POBPs	00 = Refused Programmes/Denier 000 = Not yet undertaken any programmes 01 = Assessed as not suitable for programmes 1 = SOTP 2 = Adapted SOTP 3 = Cognitive Skills Programme 4 = Healthy Relationships Programme 5 = Substance Misuse Work	Number of programmes attended
Time spent managed at Level 3 TimeatLevel3	Date – Calculate number of months from initial meeting to date, in conjunction with de-registration	Number of months
Time spent managed at Level 2 TimeatLevel2	Date - Calculate number of months from initial meeting to date, in conjunction with de-registration	Number of months
ID Noted in Diversity Considerations Diversity	1 = Yes 2 = No	1 = Yes 0 = No
Autistic Spectrum Disorder ASD	0 = No evidence of ASD 1 = Autistic Spectrum Disorder – file evidence 2 = Aspergers Syndrome – file evidence	1 = Yes 0 = No
Indications of ID from file IDIndicator	BD = File Indication of Brain Damage CI = File Indication of Cognitive Impairment HI = File Indication of Head Injury LDT = Ever engaged with a Intellectual disability service Oth = Other file indication of learning disability PC = Psychiatric Report Diagnosis of ID PY= Psychology Report Diagnosis of ID RH = Ever resided in a supported living arrangement SF = School Failure SS = Special School W1 = WAIS III score under 80 W2 = WASI score under 80	These are covered separately below – code all as 1 = Yes 0 = No

Other file indicator of ID IDOther	Free text box	1 = Yes 0 = No
Psychiatric Diagnosis of ID IDPsychiatry	0 = No Psychiatric information relating to ID 1 = Psychiatric Diagnosis of ID 2 = No Psychiatric Reports	1 = Yes, any ID file info from psychiatry 0 = No
Psychological Diagnosis of ID IDPsychology	0 = No psychological information relating to ID 1 = Psychological Diagnosis of ID 2 = No Psychological Reports	1 = Yes, any ID file info from psychology 0 = No
File indication of Cognitive Impairment IDCog	0 = No indication of Cognitive Impairment 1 = File indication of Cognitive Impairment	1 = Yes, any file information re cognitive impairment 0 = No
File indication of Head Injury IDHeadInj	0 = No indication of head injury 1 = File indication of head injury	1 = Yes, any file information re head injury 0 = No
Indication of Brain Damage IDBrain	0 = No indication of Brain Damage 1 = File indication of Brain Damage	1 = Yes, any file information re brain damage 0 = No
File indication of special schooling IDSpecialSchool	0 = No evidence of Special School 1 = File indication of Special School 2 = Evidence of statement of special educational needs	1 = Yes (evidence of special educational needs/school) 0 = No
Evidence of Disrupted Schooling IDSchoolFail	0 = No evidence of disruption to education 1 = Ever played truant 2 = Ever suspended 3 = Ever expelled 4 = Disrupted due to ill health	1 = Yes (evidence of poor attendance, suspension, expulsion) 0 = No
Evidence of Supported Living Placement IDResidence	0 = No evidence of supported living arrangements 1 = Previous history of supported living 2 = Currently in a supported living arrangement 3 = Awaiting a place in a supported living arrangement	1 = Yes 0 = No
WAIS score under 70 IDWAIS70	0 = No WAIS Score under 70 1 = WAIS Score under 70	1 = Yes 0 = No
WAIS score under 80	0 = No WAIS Score under 80 1 = WAIS Score under 80	1 = Yes 0 = No

IDWAIS80		
WASI score under 80 IDWASI80	0 = No WASI Score under 80 1 = WASI Score under 80	1 = Yes 0 = No
WASI score under 70 IDWASI70	0 = No WASI Score under 70 1 = WASI Score under 70	1 = Yes 0 = No
Indication ever engaged with the LD Team IDLDTTeam	0 = No indication ever engaged with LD team 1 = File indication of previous involvement with the LD team 2 = File indication of current involvement with the LD team	1 = Yes 0 = No
ID present IDNONID	2 or more ID factors = 1 1 or less ID factors = 0	1 = Yes 0 = No
Risk Factors Risk Factors	Currently a qualitative list, not always distinct on some minutes	Transfer to TA data sheet.
RiskofHarm	Risk of Harm – Split into OASys risk categories all using 1 -5 OASysChild OASysPublic OASysAdult OASys Staff	1 = Low 2 = Medium 3 = High 4 = Very High 5 = Not available
Risk Matrix 2000 score RiskMatrix	0 = No RM2000 1 = Low 2 = Medium 3 = High 4 = Very High	1 = Low 2 = Medium 3 = High 4 = Very High 5 = No RM2000
Licence Conditions Licencecond	6 standard for all offenders on licence 12 possible additional conditions Number of additional conditions – then visual bin and median split into low and high groups	0 = 4 or less 1 = 5 or above
Mental Health Diagnoses MentalHealth MentalHealth2	Original coding put into separate variables as below 01 = No Mental Illness 1 = Depression 2 = Anxiety 3 = Personality Disorder 4 = Schizophrenia 5 = Psychopathy – PCL-R 6 = ADHD 7 = Mental Health Referral Made 8 = Psychopathy 9 = Bipolar Disorder 10 = Psychotic	



Psychopathy psychopathy	new	1=yes 0=no
PD Personality Disorder	new	1=yes 0=no
Axis one Axis one	1 = none 2 = one or more diagnosis 3 = two or more	Recoded to mentalill
Mentalill		0 = no diagnosis 1 = one or more diagnoses
Suicideselfhar m	0 = No evidence of suicide/self injury 1 = History of suicidal ideation/suicide attempts 2 = History of self injury 3 = Risk to self – suicide attempts and self- harm	1 = Yes (any evidence of suicide/ISI or risk to self) 0 = No
Police Led Orders OrdersPolice	0 = No orders in place 1 = SOPO Sex Offender Prevention Order 2 = RHO Risk of Harm Order 3 = Disqualification Order 4 = VOO Violent Offender Order 5 = SOO Sex Offender Order (predates SOPO) 6 = ASBO	1 = Yes 0 = No
Length of Sex Offender Register Registration SORegistration n	0 = Not on the register 1 = 1 year 2 = 2 years 5 = 5 years 7 = 7 years 10 = 10 years Con = length of conditional discharge Life = Indefinite Period – Life Register = On Register duration not specified	1 = Yes on register 0 = Not on the register
Substance Misuse SubstanceM	0 = No substance misuse 1 = Heroin 2 = Amphetamines 3 = Cannabis 4 = Cocaine 5 = Ecstasy 6 = Abuse of prescription medication 7 = Previous conviction for possession 8 = Previous conviction for dealing drugs	1 = Yes 0 = No

	9 = General reference to drug use unspecified	
Alcohol Misuse AlcoholM	0 = No alcohol misuse issues 1 = Alcohol issues	1 = Yes 0 = No
Parental Factors Parents Parents2	0 = No information about parenting 1 = Father involved in crime 2 = Parents involved in crime 3 = Parental Alcoholism 4 = Parenting Style 5 = Parents collusive with offending behaviour 6 = Parental domestic abuse 7 = Parents mental illness	1 = Yes any information re parental difficulties 0 = No
Evidence of being in the care system Carehome	0 = No evidence of being in care 1 = Evidence of contact with the care system	1 = Yes 0 = No
Social Skills Socialskills	0 = No reference to social skills in file 1 = Social skills deficits 2 = Impulsive 3 = Inattentive 4 = Aggressive	1 = Yes any reference to social skills issues 0 = No
Language Issues Language	0 = No issues with language 1 = Language delays developmental 2 = Current language difficulties	1 = Yes any reference to language/communication difficulties 0 = No
History of Abuse Abuse	0 = No evidence of abuse 1 = History of sexual abuse 2 = History of physical abuse 3 = History of psychological abuse 4 = Abusive history not specified	1 = Yes 0 = No